

08866

West Virginia

Charleston

1935 - 6th Avenue

Good

April 23, 1935

West Virginia

Virginia Kirk

The National Center

The National Center, Baltimore 12, Maryland

None

1 week

June 8, 1935

April 3

June 8

The National Center, National
Institution of Health, Baltimore 12, Md.

Contract Research, 1000 North Street, W. Va.

Robert A. Kennedy

Baltimore, Md.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6885

CERTIFICATE OF DEATH

Reg. Dist. No. 06871

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b one month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 4122 Fessenden Street, N.W.			
3. NAME OF DECEASED (Type or print) Nellie First ALDER Middle ALDER Last				4. DATE OF DEATH JUNE 12 1961 Month JUNE Day 12 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1875	
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		11. BIRTHPLACE (State or foreign country) U.S. Treasury Dept. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Mr. William H. Alder W.Va.				14. MOTHER'S MAIDEN NAME Amelia C. Washington W.Va.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Frances J. Crown Address 14428 Colesville Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertension Atherosclerotic Cerebral Vascular Disease Senile Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Wascular Disease Senile DUE TO Wascular Disease Senile DUE TO Wascular Disease Senile						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1961 to June 12, 1961 , that I last saw the deceased alive on June 12, 1961 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE P.P. Andrews				ADDRESS (Street, city or town, state) 4201 FESSENDEN ST. N.W. Washington 16 D.C.			
PHYSICIAN'S NAME (Type) P.P. ANDREWS				DATE SIGNED 6-12-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/61		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland				24a. REC'D BY REGISTRAR JUN 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krasch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6886

06872

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 114 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6008 Avon Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mark		4. DATE OF DEATH Month June Day 13 Year 19 61		5. SEX Male 6. COLOR OR RACE Caucasian			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3-18-91		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Kentucky			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William R. ALLEN		14. MOTHER'S MAIDEN NAME Clara KEYES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-38-7559A		17. INFORMANT Wm. O. Allen, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b) 162.1 (c) 162.1 DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that he (this hospital) attended the deceased from Feb. 19, 1961 to June 13, 1961 , that he (we) last saw the deceased alive on June 13, 1961 , and that death occurred at 11:20PM , from the causes and on the date stated above.							
22a. SIGNATURE		22b. DATE SIGNED 6-14-61		22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, JR., LT, MC, USN			
22d. ADDRESS		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			
23d. LOCATION (City, town or county) Washington, D. C.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		24b. DATE JUN 16 '61			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 48 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

08372

08372

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Inventory of the U.S. Naval Hospital, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06873

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6903 Oakridge Ave.				d. STREET ADDRESS 6903 Oakridge Ave. =			
3. NAME OF DECEASED First Middle Last DEAN JOHNSON ALMY				4. DATE OF DEATH Month Day Year June 23, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1898	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 26		11. BIRTHPLACE (County & State, or foreign country) Portsmouth, N. H.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Almy				14. MOTHER'S MAIDEN NAME Isabella Yates Helen Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address David O. Almy-son-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of esophagus grade III DUE TO (b) 150X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10, 1961</u> to <u>June 22, 1961</u>, that (I) (we) last saw the deceased alive on <u>June 22, 1961</u>, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE Arnold Mc Nitt				22b. DATE SIGNED 6-23-61		22c. PHYSICIAN'S NAME (Type) ARNOLD McNITT	
22d. ADDRESS 1835 I Street, N. W., Washington, D.C.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 6/27/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

29 January 1964
U.S. Government of Washington, D.C.

General The Will

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ROBERT A. POMERAY
Bellevue, WA.
Arlington National Cemetery, Arlington, Virginia
1933-1964

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6888

06874

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 900 Lincoln St. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick A Bacher				4. DATE OF DEATH June 12 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/20/81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Insurance Salesman		10b. KIND OF BUSINESS OR INDUSTRY Iowa		9. AGE (In years last birthday) 79 yrs. June 12 19 61		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Bacher				14. MOTHER'S MAIDEN NAME Jenny Hickok			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 333-14-9120		17. INFORMANT Hilda Bacher(wifw)		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart failure DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 11, 1961 to June 12, 1961 , that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE G. Bowditch Hunter, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 12, 1961	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/14/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Creamtory		23d. LOCATION (City, town or county) (State) Prince George's Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The law requires that the death certificate be returned within 48 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

Montgomery

Montgomery

Montgomery

Bellevue

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6889

Item 14 Film G289 6/27/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 06875

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 40			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10404 Ga. Ave.				d. STREET ADDRESS 10404 Ga. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle BAKER Last BAKER				4. DATE OF DEATH Month June Day 21 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1883	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Russia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elliot Baker				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Rebecca Baker - 10404 Ga. Ave. S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 151X DUE TO Partial Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach & Metastases (c) Buerger Disease							INTERVAL BETWEEN ONSET AND DEATH 4 days 2 weeks 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Buerger Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10 , 19 58 to June 21 , 19 61 , that I last saw the deceased alive on June 20 , 19 61 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis X. Richardson				ADDRESS (Street, city or town, state) 11412 Vicars Mill Rd. Baltimore Md. DATE SIGNED 6/21/61			
PHYSICIAN'S NAME (Type) Francis X. Richardson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/61		22c. NAME OF CEMETERY OR CREMATORY Elesavetgrad Cemetery		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th St NW				24a. REC'D BY REGISTRAR JUN 23 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MEDICAL CERTIFICATION

2958.4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 58 Glen Echo						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital					d. STREET ADDRESS 1 12 Princeton St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARY JANE BAKER			4. DATE OF DEATH Month June Day 15 Year 19 61								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1918		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 6 Days 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Oscar H. Stitt					14. MOTHER'S MAIDEN NAME Sarah Drury						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Yes Unknown					17. INFORMANT Husband Robert J. Baker Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO (b) Chronic Glomerulo Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 15 yrs.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 9, 1961 to June 15, 1961 , that (I) (we) last saw the deceased alive on JUNE 15, 1961 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE DeWitt E. DeLaughter M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-15-61				
22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLaughter					22d. ADDRESS 3848 Porter St., N.W., Washington, D. C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/19/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines				

(M)

(I)

4890

06270

Montgomery

Montgomery

Schleider

Wetland

Suburban Hospital

12 Kensington St.

MAY

BAKER

June 12,

Female white

Nov. 21, 1914

School teacher

Tenn.

Orator H. Stitt

Garland County

Yes

Robert J. Baker

Burial 07/19/61 Arlington Nat. Cem. Arlington, Virginia

Robert A. Humphrey Bethesda, Maryland

0-15-61

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6891 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06877

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Albany</i>		c. LENGTH OF STAY in it <i>D.O.A.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i> <i>06X-2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Monty Gen. Hosp</i>				d. STREET ADDRESS <i>Ashley Traylor Court</i>			
3. NAME OF DECEASED (Type or print) <i>Tonia</i>		First <i>Tonia</i> Middle <i>Mail</i> Last <i>Baker</i>		4. DATE OF DEATH <i>June 22 1961</i>		Month <i>June</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-31-61</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Donald Baker</i>				14. MOTHER'S MAIDEN NAME <i>Virginia Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Virginia Baker (mother)</i>		Address <i>Stem 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> 475X DUE TO (b) <i>upper Respiratory Infection</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>interbed.</i> INTERVAL BETWEEN ONSET AND DEATH <i>Found collapsed in bed.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschert</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6-23-61</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-24-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lakewood Memorial Park</i>		22d. LOCATION (City, town, or country) (State) <i>Hydenville, Carroll Co. Md.</i>	
23. FUNERAL DIRECTOR <i>Arthur H. Haight</i>				ADDRESS <i>Hydenville, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur H. Haight</i>	
				DATE <i>JUN 26 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur H. Haight</i>	

1073181XV4

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08873

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Tissue" and "Tissue" are faintly visible.]

Page 4
4 hours after death
The law requires that the death certificate be executed within
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
6892																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 06878																			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC-47X-3</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLANDER REST HOME</u>					d. STREET ADDRESS <u>2306 TUNLAW RD</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET T. BAPTISTA</u>					4. DATE OF DEATH Month Day Year <u>June 11 1961</u>														
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3 1875</u>		9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>BENJAMIN F. McALWEE</u>					14. MOTHER'S MAIDEN NAME <u>?</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NO</u>					INFORMANT <u>NEPHEW</u> <u>BENJAMIN V. McALWEE</u> Address <u>4201 BROOKSIDE</u> <u>McLEAN VA</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, left breast with generalized metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>April 10, 1961</u> to <u>6/11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>61</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>James P. Kerr</u>					M.D. <u>James P. Kerr</u>					ADDRESS (Street, city or town, state) <u>Washington, DC</u>					DATE SIGNED <u>6/11/61</u>				
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>6-14-61</u>					22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEM.</u>					22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeVal FUNERAL HOME</u>					ADDRESS <u>2224 WIS Ave WASH. D.C.</u>					24a. REC'D BY REGISTRAR <u>JUN 19 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6893

CERTIFICATE OF DEATH

06879

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4819 Rugby Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Franklin Last Barnes				4. DATE OF DEATH Month June Day 30 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7		IF UNDER 24 HRS. Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Barnes				14. MOTHER'S MAIDEN NAME Rosa Queen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1901		17. INFORMANT Son - Myer H. Barnes Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Branchiopneumonia DUE TO (b) Intracerebral hemorrhage DUE TO (c) 10 days						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25th , 19 61 , to June 30 , 19 61 , that (I) (we) last saw the deceased alive on June 29, 1961 , and that death occurred at 1 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. T. Joyce				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William T. Joyce, M. D.	
22d. ADDRESS 8106 Maple Ridge Rd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 7/3/61		23c. NAME OF CEMETERY OR CREMATORY Shirwood Cem.		23d. LOCATION (City, town or county) (State) Washington DC	
24. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home Inc. m.w.				25a. REC'D BY REGISTRAR EUL 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6894

06880

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 21 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Springfield c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield d. STREET ADDRESS 5504 Damascus Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Betty Baker BARTLETT		4. DATE OF DEATH Month June Day 14 Year 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-17
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman Hempstead BAKER		14. MOTHER'S MAIDEN NAME Genevieve CAMPBELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (H) James V. Bartlett, same as #2 above	
17. INFORMANT (H) James V. Bartlett, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast, with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 24, 1961 to June 14, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 14, 1961 , and that death occurred at 6:30 AM , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE James J. Ryskamp, LT, MC, USN		22b. DATE SIGNED 6-14-61	
22c. PHYSICIAN'S NAME (Type) James J. RYSKAMP, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

108820

2884

(14)

Non-Resident

Virginia

Residence (Home)

21 days

Spokane, Idaho

U. S. Naval Hospital

3500 Buchanan Street

Boat

Lower

Maritime

June

Continued

11-24-71

at

Residence

San Francisco

Norman Hemphill B. 1111

Genevieve Campbell

(H) James V. Hemphill, owner of above

Cashmere, dressed, with necktie

3 yrs.

June 14

June 14

May 24

June 14

6-14-61

James E. RYBANSKI, JR., B. 11, MD, USA, U. S. Naval Hospital, Bethesda, Md.

Virginia

Arifin

Washington National

6-16-61

Burial

June 14

R. A. Rasmussen, Burial Home, Bethesda, Md.

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06881

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Washington D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4722</i>	
c. LENGTH OF STAY IN 1b <i>6 days</i>		d. STREET ADDRESS <i>6723 2nd St NW</i>	
3. NAME OF DECEASED (Type or print) <i>Dessie Kimball Basinger</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>		6. DATE OF DEATH <i>6 6 19 61</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>6/17/93</i>		9. AGE (In years last birthday) <i>67</i> yrs. IF UNDER 1 YEAR: Months <i>11</i> Days <i>20</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Daniel ? Clodketter</i>		14. MOTHER'S MAIDEN NAME <i>Elesia Sowers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-01-7597</i>	
17. INFORMANT <i>Hosp record</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO (b) <i>Coronary Infarct Acute</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Postero-Lateral Wall Coronary Infarct, old, multiple.</i> DUE TO (c) <i>Chronic Coronary Arterio-sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>10 days</i> <i>Undetermined</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1961</i> to <i>June 6, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 6, 1961</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>George L Ball</i> M.D.	
22b. DATE <i>June 6, 1961</i>		22c. PHYSICIAN'S NAME (Type) <i>George L Ball</i>	
22d. ADDRESS <i>10620 Georgia Ave Silver Spring Md</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/9/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Princes George's County, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>DATE JUN 9 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		25c. ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6896

06882

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>N. J.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>20 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Irvington</i>		67X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>98 Grace St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ethel</i> First		<i>Anita</i> Middle		<i>Betty</i> Last		4. DATE OF DEATH Month <i>6</i> - Day <i>24</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6-24-25</i>		9. AGE (In years last birthday) <i>35</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk Typist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Graphic Arts</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wellington Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Helen Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Washington Sanitarium & Hospital Ready</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>							
181.7 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Concussion of Cranium</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 4</i> , 1961, to <i>June 24</i> , 1961, that (I) (we) last saw the deceased alive on <i>June 24</i> , 1961, and that death occurred at <i>4:30</i> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Ethel Williams</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Lysle Williams</i>	
22d. ADDRESS <i>8700 Lakesville Rd. Silver Spring, Md.</i>				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE <i>Arthur L. Jones</i>				22g. DATE <i>JUN 27 '61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>6/26/1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hollywood Mem. Park</i>		23d. LOCATION (City, town or county) (State) <i>Union, N.J.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Sawler's Sons</i>				24a. ADDRESS <i>1756 Pa. Ave. N.W. Wash. D.C.</i>			

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MONTGOMERY MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 6 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1601 MYRTLE ROAD		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1601 MYRTLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HESTER JENNIE BECKER		4. DATE OF DEATH Month Day Year JUNE 24 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1877
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HIGH SCHOOL TEACHER, retired TEACHING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CARLISLE, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL HUTTON		14. MOTHER'S MAIDEN NAME FELECIA FORBES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 076 03 5268 NOT LOCATED	
17. INFORMANT MRS. PAUL H. ROBBONS, 1601 MYRTLE RD., SILVER SPRING		Address MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute antero-lateral coronary artery 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) occlusion with myocardial infarction DUE TO (c) and congestive failure.		INTERVAL BETWEEN ONSET AND DEATH 48 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to 24 June, 1961 , that (I) (no) last saw the deceased alive on 24 June 1961 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Ernest E. Harmon		22b. DATE SIGNED JUNE 24, 1961	
22c. PHYSICIAN'S NAME (Type) ERNEST E. HARMON		22d. ADDRESS 9301 Cokesville Rd. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/27/1961	
23c. NAME OF CEMETERY OR CREMATORY CARLISLE CEMETERY		23d. LOCATION (City, town or county) (State) CARLISLE, NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		25a. REC'D BY REGISTRAR JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Harmon			

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TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Dist. of Co.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
c. LENGTH OF STAY IN 1b <i>2 days</i>		d. STREET ADDRESS <i>3900 Watson Pl. N.W.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Norman E. Bengston</i>		4. DATE OF DEATH Month <i>June</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/3/01</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Scientific Inst. Illinois</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles A. Bengston</i>		14. MOTHER'S MAIDEN NAME <i>Martha L. Lorton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Margaret E. Bengston</i>	
17. INFORMANT <i>Margaret E. Bengston</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one causa par linea for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Myocardial infarction</i> (c) <i>3-4 days</i> DUE TO causa test.		INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral infarction, right parietal lobe</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1955</i> to <i>June 11, 1961</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>June 11, 1961</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>John E. Everett</i> M.D.		22b. DATE SIGNED <i>6/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN E. EVERETT</i>		22d. ADDRESS <i>9400 CONN AVE Kensington Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>6/14/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery Skokie, Illinois</i>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. Washington, D. C.</i>		25a. REC'D BY REGISTRAR <i>June 13 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

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(1888-1889)

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The S. H. Weber Co. Washington, D. C.
Removal of the
Memorial Park Cemetery, Chicago, Illinois

CERTIFICATE OF DEATH

Reg. Dist. No. 06885

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tahoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tahoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>7438 Baltimore</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frieda Johanna Bohlmann</i>		4. DATE OF DEATH Month Day Year <i>6 / 23 / 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/14/1891</i>
9. AGE (In years last birthday) <i>70</i>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Berlin, Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME <i>Johann Wilhelm Eulenfeld</i>		14. MOTHER'S MAIDEN NAME <i>Emilie Elizabeth Hoppe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, <i>no</i>) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>John Bohlmann</i>		Address <i>7438 Baltimore Tahoma Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Cancer</i> 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of Gall Bladder</i> DUE TO (c) <i>w/ metastases</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Surgery 3/27/61 - as above found</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/24/1961</i> to <i>6/23/1961</i> , that I last saw the deceased alive on <i>6/23/1961</i> , and that death occurred at <i>10:58</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		DATE SIGNED <i>6/23/61</i>	
PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		<i>Tahoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 27, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW. D.C.</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 27 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fries</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00888

Page One of Two

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>		<p>3. Date of birth: <u>1915-03-15</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Usual residence: <u>1234 Main St., Baltimore, Md.</u></p>		<p>6. Date of death: <u>1978-07-10</u></p>		<p>7. Time of death: <u>10:30 AM</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Cause of death: <u>Myocardial Infarction</u></p>		<p>10. Immediate cause: <u>Coronary Artery Disease</u></p>		<p>11. Underlying cause: <u>Arteriosclerosis</u></p>		<p>12. Contributing cause: <u>None</u></p>	
<p>13. Duration of illness: <u>2 weeks</u></p>		<p>14. Date of admission to hospital: <u>1978-06-25</u></p>		<p>15. Name of hospital: <u>St. Joseph's Hospital</u></p>		<p>16. Name of attending physician: <u>Dr. J. A. Smith</u></p>	
<p>17. Name of certifying physician: <u>Dr. J. A. Smith</u></p>		<p>18. Signature of certifying physician: <u>[Signature]</u></p>		<p>19. Date of certification: <u>1978-07-15</u></p>		<p>20. Place of certification: <u>Baltimore, Md.</u></p>	

IV

I

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.01, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.02.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6900

06886

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Texas b. COUNTY Nueces c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corpus Christi d. STREET ADDRESS 241 Military Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Byron Middle Emory Last BOWLING				4. DATE OF DEATH Month June Day 23 Year 19 61					
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-53		9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald E. BOWLING				14. MOTHER'S MAIDEN NAME Lena Boyles				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) No 16. SOCIAL SECURITY NO. (F) Donald E. BOWLING 17. INFORMANT Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot - DUE TO (b) Congenital Heart Disease - Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH Congenital 18 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 June 19 61 to 23 June 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 June 19 61 , and that death occurred at 6:35 PM from the causes and on the date stated above.									
22a. SIGNATURE B.H. Rice				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-24-61			
22c. PHYSICIAN'S NAME (Type) B.H. RICE LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 6-25-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town or county) Bluefield, West Virginia (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				ADDRESS 1331 E. Montgomery Ave.		25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

MANAGEMENT

Postcard (Rural)

U. S. Naval Hospital

Byron

EMORY

BOWLING

June

2-9-53

Card

Male

Virginia

Donald E. BOWLING

Don't Boyles

to ----- (1) Donald E. BOWLING, name as above

B.H. RICH AT, MD, DEN

U.S. Naval Hospital, Bethesda, Maryland

April - 2-11

Winchester, West Virginia

Rockville, Maryland

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06887

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY Bradley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #4, Box 251 - B	
3. NAME OF DECEASED (Type or print) Bryan First Mark Middle Brinkley Last		4. DATE OF DEATH June 11, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1959
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bobbie Brinkley		14. MOTHER'S MAIDEN NAME Lois Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 25, 19 61 to June 11, 19 61 , that (I) (we) last saw the deceased alive on June 11, 19 61 , and that death occurred at 2:00PM from the causes and on the date stated above.			
22a. SIGNATURE EMANUEL S. HELLMAN, M.D.		22b. DATE 6/11/61	
22c. PHYSICIAN'S NAME (Type) EMANUEL S. HELLMAN, M.D.		22d. ADDRESS The Clinical Center Bethesda 14, National Institutes Of Health Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	23b. DATE THEREOF 6-12-61	23c. NAME OF CEMETERY OR CREMATORY Moore's Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Cleveland, Tenn.
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR JUN 16 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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00288

STATE OF OHIO

1901



Benjamin Franklin

The District Court, Hamilton Co., Ohio, ss. I, the Clerk of said Court, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of said Court.

In testimony whereof, I have hereunto set my hand and the seal of said Court at Hamilton, Ohio, this 11th day of June, 1901.

Wm. H. Miller, Clerk of Court.

U. S. A.

Benjamin Franklin

The District Court, Hamilton Co., Ohio, ss. I, the Clerk of said Court, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of said Court.

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In testimony whereof, I have hereunto set my hand and the seal of said Court at Hamilton, Ohio, this 11th day of June, 1901.

Wm. H. Miller, Clerk of Court.

U. S. A.

Benjamin Franklin

1
TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6902						06888					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			e. STATE			f. COUNTY		
Montgomery			BETHESDA			Maryland			Montgomery		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
			Suburban Hospital			Rockville			500 W. Montgomery Ave.		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
First Middle Last			Month Day Year								
Josephine B. Brooks			June 12, 1961								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White				May 6, 1880		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIR PLACE (County & State, or foreign country)			
None								Connecticut			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
George H. Day				Katharine Beach				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
No				None				Martin Bennett-Son-3201 Burgundy Road Alexandria, Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction											
4201 DUE TO (b) Arteriosclerosis generalized											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Unknown											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis Bronchopneumonia											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.											
20d. INJURY OCCURRED While at work Not While at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from Sept. 1959 to May 12, 1961, that (I) (we) last saw the deceased alive on May 11, 1961, and that death occurred at 2:55 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE SIGNED											
George Sharpe 6/12/61											
22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS											
George Sharpe 10511 Sumit Ave. Kensington, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Cremation											
23b. DATE THEREOF 5/13/61											
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory											
23d. LOCATION (City, town or county) (State) Suitland, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS											
Robert A. Pumphrey Bethesda, Maryland											
25a. REC'D BY REGISTRAR DATE JUN 14 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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M

Longmont

Bellevue

Suburban Hospital

Josephine

White

Female

None

George H. Day

No

None

Katherine Beach

Connecticut

USA

May 26, 1960

MI

Brookline

June 12

of

500 W. North Street Ave.

Rockville

Maryland

Montgomery

I

May 11, 61

George Shanon

May 11, 61

Sept.

2:52 A.M.

May 12, 61

x

Deliver

10011 Summit Ave. Kensington, Md.

Robert A. Humphrey, Bellevue, Maryland

Robert A. Humphrey, Bellevue, Maryland

May 11, 61

Page 4
in 24 hours after death
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

1
6903
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06889

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarver
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center			d. STREET ADDRESS R. D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RAY Middle HENRY Last BRYAN			4. DATE OF DEATH Month June Day 9 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1913 47		9. AGE (In years last birthday) yrs. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Cale Saylor		
14. MOTHER'S MAIDEN NAME Pearl Bryan			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. unavailable			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 16 hours 11 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that he (this hospital) attended the deceased from May 24, 1961 to June 9, 1961 , that he (we) last saw the deceased alive on June 9, 1961 , and that death occurred at 8:00AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Gaffney		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/9/61	
22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/12/61		23c. NAME OF CEMETERY OR CREMATORY JARVISVILLE CEMETERY	
23d. LOCATION (City, town, or county) (State) BUFFALO TOWNSHIP P.A.		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey			
25a. REC'D BY REGISTRAR P.H.		25b. REGISTRAR'S SIGNATURE Robert A. Humphrey		DATE JUN 12 '61	

6888

CERTIFICATE OF DEATH

2003

(M)

The Clinical Center
 National Institutes of Health
 Bethesda, Maryland 20892
 Telephone: (301) 496-6000
 Fax: (301) 496-6001
 Website: www.clinicalcenter.nih.gov
 Date of Birth: 1/1/1915
 Sex: Male
 Race: White
 Marital Status: Married
 Social Security Number: [REDACTED]
 Date of Death: 1/1/2003
 Cause of Death: [REDACTED]
 Place of Death: [REDACTED]
 Signature: [REDACTED]
 Title: [REDACTED]
 Department: [REDACTED]

(Y)

Thomas H. Barker, M.D.
 Director, National
 Institutes of Health
 Bethesda, Maryland 20892
 Date: 1/1/2003
 Time: 10:00 AM
 Signature: [REDACTED]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6904

06890

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale d. STREET ADDRESS 1658-2			
3. NAME OF DECEASED (Type or print) Dorothy Helen Budzianowski				4. DATE OF DEATH June 5 1961			
5. SEX Female		6. COLOR OF RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1916	
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Manchester New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Roger Crowley			
14. MOTHER'S MAIDEN NAME Mary O'Malley				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Navy 1942-47			
16. SOCIAL SECURITY NO. Washingt				17. INFORMANT Washington Sanitarium & Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Brosch				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Brosch				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 6-5-61			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		June 7, 1961		Arlington National Cemetery		Arlington Va.	
23. FUNERAL DIRECTOR John Wilton, 254 Carroll St NW Wash. D.C.				24a. REC'D BY REGISTRAR JUN 7 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

(M)

(I)

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00220

NAME OF DECEASED: Helen Dubois
RESIDENCE: 100 W. 10th St. New York City
DATE OF DEATH: February 13, 1912
PLACE OF DEATH: St. Vincent's Hospital
CAUSE OF DEATH: Myocardial Infarction
MANNER OF DEATH: Natural
AGE: 42
SEX: Female
RACE: White
RELIGION: Catholic
EDUCATION: High School
OCCUPATION: Housewife
MARRIED: Yes
SINGLE: No
WIDOW: Yes
MILITARY SERVICE: No
PREVIOUS ILLNESS: Yes
PREVIOUS SURGERY: No
TOBACCO: No
ALCOHOL: No
DRUGS: No
OTHER: No

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6905

06891

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY P. Geo. Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 1516 Delmont Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jessie Mae Campbell		4. DATE OF DEATH Month June Day 30 Year 1961		9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 5 Days 11 Hours Min. 			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) District of Columbia			
13. FATHER'S NAME Robert Campbell		14. MOTHER'S MAIDEN NAME Elizabeth Fowler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Washington Sanitarium and Hospital Records Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 443X } DUE TO (b) Cerebro-Vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypertensive Heart disease				INTERVAL BETWEEN ONSET AND DEATH 10 days 20 days long study			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		20g. (County) 		20h. (State) 			
21. I certify that (I) (this hospital) attended the deceased from Mar 1952 to June 30, 1961 , that (I) was last saw the deceased alive on June 29, 1961 , and that death occurred at 1:57 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ernest A. Sarao		22b. DATE SIGNED 		22c. PHYSICIAN'S NAME (Type) Ernest A. Sarao			
22d. ADDRESS M.D. 7006 N. Hamp. Ave. Takoma Park, Md.		22e. REC'D BY REGISTRAR 					
22f. REGISTRAR'S SIGNATURE Arthur L. Frank		22g. DATE JUL 3 '61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City, town or county) Prince Georges		23e. (State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24b. ADDRESS Bethesda, Maryland					

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

Most likely

Takoma Park

21 days Takoma Park

Washington Sanatorium and Hospital 1216 Belmont Lane

Testis Mrs. X Campbell June 30, 1911

Female White January 19, 1911 20 11

Housewife

Robert Campbell

District of Columbia U.S.A.

Elizabeth Bowler

No

None

Washington Sanatorium and Hospital

10 days

Unknown

Robert Campbell

Hypertension Heart disease

20 days

Legs

June 30, 1911

Robert Campbell

Robert A. Sarzo

M.P. 7000 N. Hamp. Ave. Takoma Park, Md.

Burial

7/3/1911

Cedar Hill Cemetery

Prince Georges Maryland

Robert A. Pomphrey

Bethesda, Maryland

July 3, 1911

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

6-27-61
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6906

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06892

Items 14 & 15

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park W.O.A.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 099 Wash. St + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 27 Silver Spring
d. STREET ADDRESS 19511 Pin Oak Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Richard Middle Earl Last Carson

4. DATE OF DEATH
Month 6 Day 13 Year 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 1-13-92 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr 10b. KIND OF BUSINESS OR INDUSTRY Singer & Co 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Edward Carson 14. MOTHER'S MAIDEN NAME Tirzah L. Donaldson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 216-05-2567 17. INFORMANT MRS. Richard Carson Jr. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE FRACTURES OF THE SKULL
DUE TO
(b) MYOCARDIAL INFARCTION WITH CARDIAC ENLARGEMENT AND CONGESTIVE FAILURE
DUE TO
(c) MARKEDLY SEVERE CORONARY ARTERIOSCLEROSIS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) was leaving house to water flowers, when he fell down steps

20c. TIME OF INJURY Month, Day, Year 7:30 a.m. 6-13-61 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State) Silver Spring Montg Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6-14-61

EXAMINER'S NAME (Type) FRANK J. Broschart Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 6/16/61 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery Arlington, Virginia 22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR ADDRESS Wash, D.C. 24a. REC'D BY REGISTRAR JUN 15 61 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

The S.H.Hines Co., 2901 14th St. N.W.

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38800

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(M)

(1)

CONFIDENTIAL

0201

CONFIDENTIAL

0201

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98. [illegible]
99. [illegible]
100. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6908

06894

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 43 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melanie First Gaye Middle Cather Last		4. DATE OF DEATH June 10, 1961 Month June Day 10 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years lost birthday) 5 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Cather		14. MOTHER'S MAIDEN NAME Patricia Sutherland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Gastrointestinal Hemorrhage IMMEDIATE CAUSE (a) 204.3 DUE TO Acute Lymphatic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Year INTERVAL BETWEEN ONSET AND DEATH 4 Days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 29, 1961 , to June 10, 1961 , that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred at 11:50 AM from the causes and on the date stated above.			
22a. SIGNATURE E.S. Hellman M.D.		22b. DATE SIGNED 6-11-61	
22c. PHYSICIAN'S NAME (Type) E.S. Hellman M.D.		22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/1961	
23c. NAME OF CEMETERY OR CREMATORY St. Charles Church Cemetery Glymont, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. La Plata, Md.		25a. REC'D BY REGISTRAR JUN 16 '61	
		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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6910

CERTIFICATE OF DEATH

Reg. Dist. No. 06897

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Colesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mary Lee Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John C. Cissel</u>		4. DATE OF DEATH <u>June 27</u> 19 <u>61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/76</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilbur F. Cissel</u>		14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-8868</u>	
17. INFORMANT <u>Mrs Dorothy Lehmkuhl</u> Address <u>2109 Belorden Blvd Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>331X</u> DUE TO <u>Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>4 days</u> (c) <u>Interval between onset and death</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 one</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 1, 1957</u> to <u>June 27, 1961</u> , that I last saw the deceased alive on <u>June 26, 1961</u> , and that death occurred at <u>6 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. Silver Spring Md.</u> DATE SIGNED <u>6-27-61</u>	
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>		<u>1919 Seminary Rd., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/29/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>	22d. LOCATION (City, town, or county) (State) <u>Highland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Howard</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

10000

NEW YORK STATE DEPT. OF HEALTH

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, cause of death, etc.]

[Faint text at the bottom of the page, possibly a signature or official stamp area.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6909

06895

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Woods (Rockville)</u>	
c. LENGTH OF STAY IN lb <u>DOA</u>		d. STREET ADDRESS <u>4414 Ives Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Thomas</u> Last <u>Chilcont</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 17 1961</u>
9. AGE (In years last birthday) yrs. <u>3</u> Months <u>22</u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Washington, DC.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>USA.</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Melvin Chilcont</u>		14. MOTHER'S MAIDEN NAME <u>Irene E. Bartkovich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT Address <u>(Father) Thomas Chilcont (same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Patient ductus arteriosus; Atrial septal defect; Hypertrophy</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>DOA</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-17, 1961</u> to <u>4-7, 1961</u> , that (I) (we) last saw the deceased alive on <u>4-7, 1961</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Carl Silverman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Carl Silverman</u>		22b. DATE SIGNED <u>June 8, 1961</u>	
22d. ADDRESS <u>12801 Evanston St Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., 8434 Georgia Ave., Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>June 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>			

6050

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

OR

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6911

CERTIFICATE OF DEATH

06898

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY in 1b 2 weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1213 BROADWOOD DRIVE				d. STREET ADDRESS 1213 BROADWOOD DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH		First Middle Last CLISER		4. DATE OF DEATH JUNE 2 19 61		Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 6, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) PAGE CO. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM JEWELL		14. MOTHER'S MAIDEN NAME BERTIE SMELSER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Oliver J. Cliser		1213 Broadwood Dr. Rockville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma stomach (a), stating the underlying cause last. DUE TO with metastases (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/5/61 , 19....., to 6/2/61 , 19....., that (I) (we) last saw the deceased alive on 6/2/61 , 19....., and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Patrick C. Jameson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/61	
22c. PHYSICIAN'S NAME (Type) Patrick C. Jameson				22d. ADDRESS 12,020 Georgia Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George County Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska		ADDRESS 8434 Georgia Ave. Silver Spring Md.		25a. REC'D BY REGISTRAR JUN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

2280



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6912
MONTGOMERY
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MAY 13 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montg.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Montg.</i>	
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>		c. LENGTH OF STAY IN lb <i>47 days</i>	
6. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caring Nursing Home</i>		d. STREET ADDRESS <i>106 Elm Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Albert Valentine Cobb</i>		4. DATE OF DEATH <i>6/11/1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 2, 1880</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Windsor N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Albert Valentine Cobb</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Sharrock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. C. Gochisor</i>		1015 Elm Ave. <i>Tahoma Park Ind.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>broncho pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gen. arteriosclerosis</i> DUE TO <i>Senile Dementia</i> (c) <i>2 days</i> 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/4/1955</i> to <i>6/11/1961</i> , that (I) (we) last saw the deceased alive on <i>6/11/1961</i> , and that death occurred at <i>6:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>H. T. Morse</i>		22b. DATE <i>6/11/61</i> SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>H. T. Morse</i>		22d. ADDRESS <i>7030 Carroll Ave. Tahoma Park, Ind.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 14, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Edgewood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Windsor, North Carolina</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>254 Carroll St. N.W. DC</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		DATE <i>JUN 13 '61</i>	

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CERTIFICATE OF DEATH

0015

(M)

(1)

[Faint, illegible text, likely a death certificate form with fields for name, date, and cause of death.]

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STATE OF OHIO

1913

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06901

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 59 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 1000 Madison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel Gertrude CONDYLES		4. DATE OF DEATH Month Day Year June 22 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-96
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days 65	IF UNDER 24 HRS. Hours Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (County & State, or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John K. BLACKWELL	
14. MOTHER'S MAIDEN NAME Rhoda HENDERSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address (S) Eugene G. Condyle, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal shutdown with uremia DUE TO (b) Carcinoma of the cervix DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from April 24, 19 61 to June 22, 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 22, 19 61 , and that death occurred at 3:20AM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Anctil, Jr. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 6-22-61
22c. PHYSICIAN'S NAME (Type) Arthur O. ANCTIL, JR., MC, LT, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-24-61	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION (City, town or county) (State) Richmond Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Bliley, 3rd & Marshall Sts., Richmond, Va.		25a. REC'D BY REGISTRAR JUN 26 '61 DATE	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

(M)

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6011

Memorandum

Subject: ()

U. S. Naval Hospital

Address

Georgetown

CHURCH

June 25

61

Person

Constitution

x

2-3-36

43

Honorable

- - - - -

South Carolina

USA

John K. BROWN

John K. BROWN

NO

(2) Eugene G. Connelley, same as above

(1)

April 24 1936
June 25 1936

June 25

Arthur O. WINTERS, JR., MC, LT, USN U. S. Naval Hospital, Bethesda, Md.

Virginia

Richmond

Riverview Cemetery

6-24-36

Buried

Joe. W. Bixby, 3rd & Marshall Sts., Richmond, Va.

June 26 1936

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6915

06902

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY EXETER Calvert							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY in 1b 44 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barstow P.O., Calvert Co.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS - - - - -				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				First Mamie		Middle COPSEY		Last COPSEY		4. DATE OF DEATH Month June		Day 22		Year 19 61	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-86		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (County & State, or foreign country) Mryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Morris SUITE				14. MOTHER'S MAIDEN NAME Rosie WILLIAMS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Evelyn Black (D), same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Penal shutdown with uremia DUE TO (b) Carcinoma of the cervix DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 9, 1961 to June 22, 1961 , that (we) last saw the deceased alive on June 22, 1961 , and that death occurred at 6:35AM from the causes and on the date stated above.															
22a. SIGNATURE Arthur O. ANCTIL, JR.				M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-22-61			
22c. PHYSICIAN'S NAME (Type) Arthur O. ANCTIL, JR., LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery				23d. LOCATION (City, town or county) Barstow Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Harkness Funeral Home, Mutual, Md.						25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harkness							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Bestanden (Favorit)

POSTAL WILLIAMS

Figure 5

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TO HOSPITAL, retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 2 Film G288 6/15/61 lwk											
06903											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 month				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Delta			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS Rt 1 #3 Asbury Methodist Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert H. Craig				4. DATE OF DEATH June 10 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/13/72		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner				10b. KIND OF BUSINESS OR INDUSTRY Agri.				11. BIRTHPLACE (County & State, or foreign country) Delta, Penna.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Henry Craig				14. MOTHER'S MAIDEN NAME Elizabeth Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT Mrs. Edith Morris, Delta, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 600.0 DUE TO Wernia Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (b) DUE TO abdominal wall abscess following Aggravated (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): abdominal wall abscess following Aggravated											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Rockville - Md.				20g. (County) DELTA				20h. (State) PA.			
21. I certify that (I) (this hospital) attended the deceased from 6/11/61 to 6/10/61 , that (I) (we) last saw the deceased alive on 6/10/61 , and that death occurred at 6/10/61 M, from the causes and on the date stated above.											
22a. SIGNATURE Arthur F. Woodward				22b. DATE SIGNED June 10, 1961							
22c. PHYSICIAN'S NAME (Type) Arthur F. Woodward				22d. ADDRESS Rockville - Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF June 13, 1961				23c. NAME OF CEMETERY OR CREMATORY STATE RIDGE			
23d. LOCATION (City, town or county) DELTA				23e. (State) PA.							
24. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison				24b. ADDRESS DELTA, PA.				25a. REC'D BY REGISTRAR JUN 13 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Huns											

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Montgomery
Alabama
June 13, 1964
Dear Mr. [illegible]
I am writing to you in response to your letter of June 10, 1964, regarding the matter of [illegible].
I am sorry that I cannot provide you with a more definitive answer at this time, but the situation is complex and requires further investigation.
I will be sure to keep you informed as soon as a final decision has been reached.
Very truly yours,
[illegible signature]
[illegible title]



Enclosed for you are two copies of the report of the [illegible] Committee on the [illegible] matter.
I hope this information is helpful to you.
Sincerely,
[illegible signature]
[illegible title]
June 13, 1964
[illegible address]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

CERTIFICATE OF DEATH

Reg. Dist. No. 06904

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		c. LENGTH OF STAY IN 1b <u>75 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ober</u> Middle <u>William</u> Last <u>DAILEY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 10, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew J. Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Savilla Nicholson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-8041</u>	
17. INFORMANT <u>Mrs. Nellie Howes - daughter - Brookeville, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO (c) <u>Chronic Pulmonary Fibrosis + Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aortic Aneurysm.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hrs.</u> years. <u>—</u> years. <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>June</u> , 1961, that I last saw the deceased alive on <u>June 13</u> , 1961, and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY Md.</u> DATE SIGNED <u>6-13-61</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-15-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookeville</u>	22d. LOCATION (City, town, or county) (State) <u>Brookeville, Mont. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MONTGOMERY COUNTY
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6913

06905

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
c. LENGTH OF STAY IN b. <u>1 day</u>				d. STREET ADDRESS <u>Pine Ridge Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>R.</u> Last <u>Daniels</u>				4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23 - 1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Constructor</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>HORACE DANIELS</u>				14. MOTHER'S M maiden NAME <u>Mary Mac Namey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Patient</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis heart dis.</u> DUE TO (c) <u>Myocardial infarction</u> <u>Causes of Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Two days?</u> <u>Two days?</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
22c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		22f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/19/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/19/61</u> , 19 <u>61</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas H Wolohon</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohon</u>				22d. ADDRESS <u>7600 Benell Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)		23b. DATE THEREOF <u>June 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Beltville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Garcho Son</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 23 '61</u>			
ADDRESS <u>4739 3rd Ave Hyattsville, Md</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

3

6949

25

a. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

8714 CAMERON STREET. APT. #208

Davis

67

6.3.

Maude Norton

Address

Kathryn Noonan Davis, 8714 Cameron St., SS., Md.

CORONARY OCCLUSION

* F.R.S.

CORONARY ATHEROSCLEROSIS

5/15/74

北九州市

YEARS.

PART II. OTHER SIGNIFICANT CONDITIONS ~~CONTRIBUTING TO DEATH~~ BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

PEPTIC ULCER

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

21. I **certify** that (I) (this hospital) attended the deceased from MAY 27, 1961, to JUNE 17, 1961, that (I) (we) last saw the deceased alive on JUNE 17, 1961, and that death occurred at 1038A from the causes and on the date stated above.

22b. DATE
SIGNED

JAMES A. ROBERTS M.D.

8907 GEORGIA AVE. SILVER SPRING, MARYLAND

Gate of Heaven Cemetery

Montgomery County, Maryland

Funeral Director's Signature: Wagner E. Pumphrey, Inc., ADDRESS: Silver Spring, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 22 '61

Arthur S. Kraus

VR A15 (4)
15M 9/60

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CONFIDENTIAL

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6920											
06907											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5600 Western Avenue					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington						c. LENGTH OF STAY IN TB					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) PAUL A. DAVIS						4. DATE OF DEATH June 2, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President				10b. KIND OF BUSINESS OR INDUSTRY Electrical Fixture Firm				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Davis						14. MOTHER'S MAIDEN NAME Mildred Hill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Imogene E. Davis-Wife-same 2d						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-27 , 19 61 , to 6-2 , 19 61 , that (I) (was) last saw the deceased alive on 6-2 , 19 61 , and that death occurred at 11:30 A M, from the causes and on the date stated above.											
22a. SIGNATURE R. Hammond Misch						22b. DATE SIGNED June 2/61					
22c. PHYSICIAN'S NAME (Type) KEMP H. MISH						22d. ADDRESS Washington, 2011 - R Street, N.W., D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/5/61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						25a. REC'D BY REGISTRAR Bethesda, Maryland DATE JUN 8 '61					
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					



Montgomery

Kane, John

Washington, D.C. 20540

5000 Lehigh Avenue

June 2, 1964

White

June 2, 1964

Electrical
Sixth Floor

Pennsylvania

USA

James P. Davis

Delaware Hill

Yes
Unborn Joseph P. Davis-Wilson 25

June 2/64

Washington

2011 - R Street, N.W.

2011 - R Street, N.W.

Rock Creek Cemetery

6/2/64

Burial

Bethesda, Maryland

Robert A. Humphrey

Washington, D.C.

64

06303

692-

Arthur S. Kraus

VR A15 (4)
15M 9/60

(M)

1921

1921

Memorandum

Subject: (None)

See days

Heavy Chase

U. S. Naval Hospital

Heavy Chase Club

Oliver

See

MOVING

June 21

of

Conclusion

X

8-25-21

VI

October

U. S. Navy

Delaware

USA

General TOWNE

NAVY HUSBY

See 1921-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

Continuation of 1921-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

June 21

of

Sept. 27 1921

June 21

of

1-21-21

NAVY & MARINE CORPS, U. S. NAVAL HOSPITAL, BOSTON, MA.

Bureau

Arlington National

Arlington

Virginia

Joe. Gowers & Sons, 1150 Penna. Ave., WASHINGTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522

CERTIFICATE OF DEATH

Reg. Dist. No. 06910

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>757 Eastern Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Lucille</u> Last <u>Drummond</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13, 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Gilbert</u>			14. MOTHER'S MAIDEN NAME <u>Louisa Grossman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Washington Sanitarium and Hospital Records</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe coronary insufficiency</u> DUE TO (c) <u>Severe arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH minutes <u>minutes</u> years <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/19/61</u> , 19 <u>61</u> , to <u>6/20/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/19/61</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5030 Carroll Ave</u> DATE SIGNED <u>6/20/61</u> ACTUAL SIGNATURE <u>H. T. Morse</u> M.D. PHYSICIAN'S NAME (Type) <u>H. T. Morse</u> <u>Takoma Park 12</u> <u>MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>June 23-61</u>		<u>Large Hill Cem.</u>		<u>Hyattsville-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St. N.W.-D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6923

06911

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 31 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2023 Lanier Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2023 Lanier Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle M. Last Gubner		4. DATE OF DEATH Month June Day 21 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1900
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Deacon Yocum		14. MOTHER'S MAIDEN NAME Abbie G. Huffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-42-1746	
17. INFORMANT Mrs. Arthur L. Hanson		Address 2023 Lanier Drive Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestinal (small) tract. 152.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 to 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/5/61 , 19 60 to 6/21/61 , 19 61 , that (I) (we) last saw the deceased alive on June 20, 1961 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A. B. Little		22b. DATE SIGNED June 21, 1961	
22c. PHYSICIAN'S NAME (Type) A. B. LITTLE MD		22d. ADDRESS 6911 Fifth Street, N.W. Washington D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/23/61	
23c. NAME OF CEMETERY*OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town or county) (State) Gaithersburg, Montgomery, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Ziska		25a. REC'D BY REGISTRAR June 27 '61	
ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6924

08158

1. PLACE OF DEATH a. COUNTY Montgomery 3404 W. Coquelin Terrace Ch. Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Ch. Md. 3404-W. Coquelin Ter. Ch. Md. Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 51	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mrs. Middle Mary Last H. Durbin		4. DATE OF DEATH Month June Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15 1883
9. AGE (In years last birthday) 78 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bolling Green, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Fleming,		14. MOTHER'S MAIDEN NAME Margaret Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret P. Durbin-		Address 3404-W. Coquelin Ter. Ch. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Coronary artery disease DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General vascularization, Diabetes mellitus, Pulmonary embolism			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 29 19 54 to June 28 19 61 , that (I) (we) last saw the deceased alive on June 26 19 61 , and that death occurred at 11:30 A. from the causes and on the date stated above.			
22a. SIGNATURE Blaine H. Elg		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Blaine H. Elg		22d. ADDRESS 8641 Colesville Road, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61	
23c. NAME OF CEMETERY OR CREMATORY Bowling Green		23d. LOCATION (City, town, or county) (State) Kentucky,	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Haulon		25a. REC'D BY REGISTRAR DATE JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6825

06912

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 30 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 210 Cromwell Terrace, N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle Mary Last Dyson		4. DATE OF DEATH Month June Day 22 , Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1908
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Duckett		14. MOTHER'S MAIDEN NAME Janie Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-053585	
17. INFORMANT The Medical Record		Address Unavailable The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastases from DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinoma of Cervix with DUE TO (c) Metastases to lung		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year 3 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1961 to June 22, 1961 , that (I) (we) last saw the deceased alive on June 22, 1961 , and that death occurred at 6:00 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Donald L. Morton M.D.		22b. DATE 6/22/61	
22c. PHYSICIAN'S NAME (Type) DONALD L. MORTON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/26/61	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEMETERY		23d. LOCATION (City, town, or county) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Alex. Pope		25a. REC'D BY REGISTRAR 414-15th ST S.E.	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		DATE JUN 23 '61	

03913

Ministry of Defense

Washington

30 days

October

210 Grosvenor Terrace, N.Y.

The Clinical Center, Bethesda 14, Md.

Oct 22, 1958

London

May

James

April 15, 1958

Female

U.S.A.

Ministry of Defense

London

October

James Williams

Henry Jackson

210 Grosvenor Terrace, N.Y.

The Clinical Center, Bethesda 14, Maryland

1 month

General Information

1 year

Continuation of service with

3 months

Information to James

Oct 22, 1958

Oct 22, 1958

Oct 22, 1958

Oct 22, 1958

Oct 22, 1958

The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

Oct 22, 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G289 6/26/61 ink

CERTIFICATE OF DEATH

Reg. Dist. No.

06913

6926

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MD b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d. STREET ADDRESS 5504 -43rd. Place			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle E. Last EBERHART				4. DATE OF DEATH Month 6 - Day 18 - Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-66	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JACOB PARKER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT WILLIAM F. EBERHART				Address 5504 43RD PLACE HYATTSVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Unable to state INTERVAL BETWEEN ONSET AND DEATH about 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4 , 19 57 , to June 18 , 19 61 , that I last saw the deceased alive on June 11 , 19 61 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Caron H. Traum				ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring MD			
DATE SIGNED 6/19/61							
PHYSICIAN'S NAME (Type) HARRON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-21-1961		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CITY CEM		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 21 '61	
				24b. REGISTRAR'S SIGNATURE Arthur J. Henshaw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4
TO HOSPITAL OR A N D I N G P H Y S I C I A N : The law requires that the death certificate be executed within 72 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6927
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06914

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b # 1 Year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg		d. STREET ADDRESS 105 James St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 James St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle MYRTLE Last EYLER		4. DATE OF DEATH Month June Day 19 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13 1890
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months 71 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pract. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Harrison		14. MOTHER'S MAIDEN NAME Cornelia Warthen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578 36 8319	
17. INFORMANT Leslie E. Mullineaux		Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Inoperable Cancer of breasts (c) Possible generalized Metastasis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 19 1961 to 6/19 1961 , that (I) (we) last saw the deceased alive on 6/10 1961 , and that death occurred at 6/19 1961 M, from the causes and on the date stated above.			
22a. SIGNATURE Lucius R. Leal		22b. DATE SIGNED 6/19 1961	
22c. PHYSICIAN'S NAME (Type) L. R. Leal		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22 1961	
23c. NAME OF CEMETERY OR CREMATORY Hyattstown		23d. LOCATION (City, town, or county) (State) Hyattstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE Charles R. Hume	

Possible Generalized Metastasis
Inoperable Cancer of breasts
Heart Failure

April 11 1961

Wittman, J.

11 11 61

Wittman, J.
11 11 61

Wittman, J. 11 11 61

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6928

06915

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Olney			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Josiah Finneyfrock				4. DATE OF DEATH Month Day Year 6 11 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Finneyfrock				14. MOTHER'S MAIDEN NAME Anna Schutly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217-34-1061		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arterio Sclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 11 hrs. years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from 6/11 19 61 , to 6/11 19 61 , that (I) (we) last saw the deceased alive on 6/11 19 61 , and that death occurred at 7:30 M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Richard A. Yates M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Yates				22d. ADDRESS Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-61		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) Olney, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

6929

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06916

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi	
c. LENGTH OF STAY IN 1b 4/9/61-6-8/61		d. STREET ADDRESS 2526 Buck Lodge Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jessie Marie Fitzwater		4. DATE OF DEATH June 8 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3 - 1896
9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Manuel		14. MOTHER'S MAIDEN NAME Eva Meeks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 3	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease 350X DUE TO Cerebral arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Cardiac Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/9 1961 to 6/8 1961 , that (I) (we) last saw the deceased alive on 6/8 1961 , and that death occurred at 6/8 1961 M, from the causes and on the date stated above.			
22a. SIGNATURE J. E. Virnstein		22b. DATE SIGNED 6/8/61	
22c. PHYSICIAN'S NAME (Type) J. E. VIRNSTEIN		22d. ADDRESS 3311-16-77th Wash. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/10/61	
23c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery		23d. LOCATION (City, town, or county) (State) Nokesville, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Hines Co		25a. REC'D BY REGISTRAR 290114SNV	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE JUN 9 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6930
M
050
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06917

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY West Pittston e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Harold Last Flannery		4. DATE OF DEATH Month June Day 3, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1898
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR Months 6 Days 3 Hours 1 Min.	11. UNDER 24 HRS. Months 6 Days 3 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge		10b. KIND OF BUSINESS OR INDUSTRY Law	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Flannery		14. MOTHER'S MAIDEN NAME Bridget Tighe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & chronic respiratory insufficiency 526X DUE TO Bronchiectasis & emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) years DUE TO (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis of aorta, coronaries & cerebral vessels - severe			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2, 1961 to June 3, 1961 , that (I) (we) last saw the deceased alive on June 3, 1961 , and that death occurred at 4:30PM M, from the causes and on the date stated above.			
22a. SIGNATURE O. W. McBride		22b. DATE SIGNED 6/4/61	
22c. PHYSICIAN'S NAME (Type) Orlando W. McBride, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/6/61	
23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City, town, or county) (State) Pittston, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

மதுரை: 29 சூன்

TABLE 1

The National Center for Botanical Illustration

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1502

210

5985 • J. Neurosci., July 26, 2006 • 26(30):5981–5984

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0000-0001-9786-111X

Figure 2. 3 sub1.

12

2000

2515

The Minister, General, National Institute of Health, Bethesda, Maryland

• C •

TO HOSPITAL OR A Dying Physician: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6931

Item 9 Film G289 6/28/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

06918

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 E. Argyle Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>M.</u> Last <u>Foley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert J. Foley</u>				14. MOTHER'S MAIDEN NAME <u>Julia Meagher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>--</u>			
17. INFORMANT <u>Ann M. Foley</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 2865 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>malnutrition, mental depression</u> DUE TO (c) <u>1 year.</u> INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radiation mastectomy for carcinoma of breast 1949.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>June 21, 1961</u> , that I last saw the deceased alive on <u>June 15, 1961</u> , and that death occurred at <u>110 S. Washington St.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. H. Lenthum</u>				ADDRESS (Street, city or town-state) <u>110 S. Washington St. - 6/21/61</u>			
DATE SIGNED <u>6/21/61</u>							
PHYSICIAN'S NAME (Type) <u>WILLIAM A. LINTHICUM, M.D.</u>				ADDRESS <u>110 South Washington St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE <u>6/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Towson Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 E. Montg. Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 23 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1931

CERTIFICATE OF DEATH

1931

141

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6932

06919

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland D C b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 4200 Cathedral Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin (nmi) FORD				4. DATE OF DEATH Month Day Year June 5 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/90	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 4 Days 3		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Manager				10b. KIND OF BUSINESS OR INDUSTRY Bogley Reas Est.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Henry Jones Ford				14. MOTHER'S MAIDEN NAME Bertha Batory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Wife Kathryn Ford (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, massive 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Old inactive rheumatic heart disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. May 12, 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 				20f. (City or town) (County) (State) May 12, 1961 to June 5, 1961			
21. I certify that (I) (this hospital) attended the deceased from May 12, 1961 to June 5, 1961 , that (I) (we) last saw the deceased alive on June 5, 1961 and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE George Buchanan				22b. DATE SIGNED June 5, 61			
22c. PHYSICIAN'S NAME (Type) George Buchanan				22d. ADDRESS 1834 Eye St. N.W. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/6/1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR JUN 8 1961			
ADDRESS Bethesda, Maryland				25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

0932

TESTIFICATE OF DEATH

08910

4300 Cathedral Avenue, N.W.

FORD (name)

3650

Bogey Road, Tennessee

Henry Bogey

Unknown

Old station in front of the house
Corner of 2nd and 3rd
11th Street, N.W.

No record

May 10, 1902

George A. Henshaw

Place Georges Maryland

Cedar Hill Cemetery

Creation 6/6/1901

Robert A. Henshaw, Bethesda, Maryland

1

6933

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06920

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown	
		d. STREET ADDRESS 31 Evans Street	
3. NAME OF DECEASED (Type or print) First Helen Middle (N.K.) Last Galderisi		4. DATE OF DEATH Month June Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1905
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Koballa		14. MOTHER'S MAIDEN NAME Mary Hardy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma of Right main Bronchus DUE TO with metastasis to Adrenals, lymph Nodes, Thyroid, and pancreas. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **May 14, 19 61** to **June 12, 19 61** that (I) (we) last saw the deceased alive on **June 12, 19 61**, and that death occurred **2:15 PM** from the causes and on the date stated above.

22a. SIGNATURE Leo Stolbach	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-12-61	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Leo Stolbach M.D.	22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 6-13-1961	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City, town, or county) (State) Hopwood, Pa.
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24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler & Sons, Inc. 1756-Pa. Ave. N.W.	ADDRESS Wash. 6, D.C.	25a. REC'D BY REGISTRAR DATE JUN 14 1961	25b. REGISTRAR'S SIGNATURE Carlton S. Probst
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00000

CERTIFICATE OF DEATH

1953

M

Montgomery

Montgomery

Alabama

29 days

Postcard

31 years old

The Clinical Center

Alcohol

(1953)

Refers

June

November 12, 1953

Female white

James A. Davis

Home

Housewife

George A. Davis

The Clinical Center

The Clinical Center, Birmingham, Alabama

Home

James A. Davis, 31 years old, white female, born November 12, 1922, died November 12, 1953, at The Clinical Center, Birmingham, Alabama, of a heart attack.

May 12, 1953

June 12, 1953

1953

The Clinical Center, Birmingham, Alabama

Two doctors

James A. Davis, 31 years old, white female, born November 12, 1922, died November 12, 1953, at The Clinical Center, Birmingham, Alabama, of a heart attack.

1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center					d. STREET ADDRESS 310 North Van Buren Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle PAULINE Last GENIES					4. DATE OF DEATH Month June Day 13, Year 1961				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1914		9. AGE (In years last birthday) yrs. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Reuben Dove					14. MOTHER'S MAIDEN NAME Flora Hogan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular collapse DUE TO 174X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Pseudomonas septicemia DUE TO 3wks (c) Adenocarcinoma of the uterus several months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3wks several months									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3, 1961 to June 13, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 13, 1961 , and that death occurred at 11:35AM from the causes and on the date stated above.									
22a. SIGNATURE David T. Crawford M.D.					22b. DATE SIGNED 6/13/61				
22c. PHYSICIAN'S NAME (Type) David T. Crawford, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				
23a. BURIAL, CREMATION, (specify) Burial		23b. DATE THEREOF 6/17/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,			23d. LOCATION (City, town, or county) (State) Rockville, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworde					25a. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

(M)

Resident Physician
The Clinical Center
110 North Van Buren Street
Chicago, Ill.

(I)

Female
Hemorrhoids
Lenther House
Not available at the Clinical Center, Bethesda, Md., Maryland
September 14, 1931
June 13, 1931

Dr. J. C. Gump
The Clinical Center, National
Institute of Health, Bethesda, Md., Maryland
June 13, 1931

Dr. J. C. Gump
The Clinical Center, National
Institute of Health, Bethesda, Md., Maryland
June 13, 1931
Resident Physician
The Clinical Center
110 North Van Buren Street
Chicago, Ill.

1

6935

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06922

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Malcolm Drive		d. STREET ADDRESS 903 Malcolm Drive 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEOGHEGAN, EARL		4. DATE OF DEATH Month 6 Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S.N. Air Stat	
11. BIRTHPLACE (State or foreign country) Shelby County, Ky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. Married Fathers name John Geoghegan		14. MOTHER'S MAIDEN NAME Elizabeth Caplinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 400 28 2119	
17. INFORMANT Claude Geoghegan		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Sensitivity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 59 to June 19 61 , that (I) (we) last saw the deceased alive on June 3 19 61 , and that death occurred at 7:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 6-17-61	
22c. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald		22d. ADDRESS 217 UNIVERSITY BLVD E. S.E. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-1961	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town, or county) (State) Silver Spring, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		25a. REC'D BY REGISTRAR Wash, DC	
25b. REGISTRAR'S SIGNATURE June 21 '61			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AP CORONER HAS BEEN NOTIFIED AND APPROVES.

6536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06923

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 57 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				d. STREET ADDRESS Box 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle DIONISUS Last GLOYD				4. DATE OF DEATH Month 6 Day 1 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/88	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent				10b. KIND OF BUSINESS OR INDUSTRY insurance		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob A. Gloyd				14. MOTHER'S MAIDEN NAME Elizabeth Clents			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA DOE TO MYOCARDIAL INFARCTION (OLD) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify (I) (this hospital) attended the deceased from 5/3/5 19 46 to 6/1 19 46 , that (I) (we) last saw the deceased alive on 6/1 19 46 , and that death occurred at 7:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6-5-61		23c. NAME OF CEMETERY OR CREMATORY St Rose		23d. LOCATION (City, town, or county) (State) Gaithersburg R. H. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas				25a. REC'D BY REGISTRAR DATE IN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1201

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6937

06924

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1125 Spring Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Joseph (NMM) Gottlieb</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-76</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>					
13. FATHER'S NAME <u>Abraham Gottlieb</u>				14. MOTHER'S MAIDEN NAME <u>Judith Vashevsky</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>p't Hosp. record.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured colon diverticulum</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senilized atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>June 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1961</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Abraham W. D. Anisat</u>				22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. D. ANISAT</u>		22d. ADDRESS <u>927 Pershing B Silver Spring MD</u>		22b. DATE SIGNED <u>6/5/61</u>		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JUNE 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON CEMETERY</u>		23d. LOCATION (City, town or county) <u>BROOKLYN</u> (State) <u>N.Y.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Trans</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

43634

1880

(M)

(I)

THE NATIONAL ARCHIVES
COLLECTION OF THE
UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G288 6/16/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. **06925**

1. PLACE OF DEATH COUNTY Carroll Rest Home Montgomery Kensington Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. c. LENGTH OF STAY IN 1b Six Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home 10231 Carroll Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward O Gramm Sr.		4. DATE OF DEATH Month JUNE Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8, 1876
9. AGE (In years last birthday) 84 1/2 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 10b. KIND OF BUSINESS OR INDUSTRY Electric Bussiness Washington D. C. 11. BIRTHPLACE (State or foreign country) U. S. A. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jonathan Gramm		14. MOTHER'S MAIDEN NAME Agnes Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Marie M Milans Address 816 Randolph Street N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH 13, 1956 , to JUNE 10, 1961 , that I last saw the deceased alive on JUNE 10 , 19 61 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Kenyan Landon</i> M.D.		ADDRESS (Street, city or town, state) 5206 NORWAY DR. DATE SIGNED 6/10/61	
PHYSICIAN'S NAME (Type) CHEVY CHAST, MD		22a. BURIAL, CREMATION, ETC. (Specify) Burial 22b. DATE THEREOF June 13, 1961 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem 22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. K. Hunte</i> ADDRESS W. K. Hunte & Son 5732 Co. Ave N. W.		24a. REC'D BY REGISTRAR DATE JUN 14 '61 24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

L. I. Rosenberg & Son, Inc., New York

June 17, 1961

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>2211 L. St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna E. Green</u>				4. DATE OF DEATH Month Day Year <u>June 12 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-06</u>	
9. AGE (in years last birthday) <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DO</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>578-44-0977</u>		17. INFORMANT <u>Elsie Moore</u> Address <u>W 25th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-12-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>		22d. LOCATION (City, town, or country) (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>MARION H. BOYD</u>				ADDRESS <u>719 Kennedy</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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WINDING, EXAMINER, CLERK OF COURT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6940

CERTIFICATE OF DEATH

Reg. Dist. No. 06927

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1532 Red Oak Drive		d. STREET ADDRESS 10X-2	
3. NAME OF DECEASED (Type or print) First ALTA Middle LEONA Last HARNE		4. DATE OF DEATH Month June Day 14 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 March 1878
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph L. Redmond		14. MOTHER'S MAIDEN NAME Oliva Pryor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Lillian C. Landis (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of recto sigmoid 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal myelonephritis		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 30, 1960 to June 14, 1961 , that I last saw the deceased alive on June 14, 1961 , and that death occurred at 1:19 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sydney Leventhal M.D.		ADDRESS (Street, city or town, state) 9210 Coleville Rd., Silver Spring, Md.	
DATE SIGNED June 17, 1961			
PHYSICIAN'S NAME (Type) Sydney Leventhal			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-17-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

6841

CERTIFICATE OF DEATH

Reg. Dist. No. 06928

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. 59			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7109 Radnor Rd.				d. STREET ADDRESS 7109 Radnor Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HELEN Middle L. Last HEIDER				4. DATE OF DEATH Month June Day 16th Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1912	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Leba				14. MOTHER'S MAIDEN NAME Anna Lechvoich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-18-6120		17. INFORMANT Mr. William F. Heider, 7109 Radnor Rd. Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Colon c Metastasis 153.8 DUE TO to Liver, etc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 11, 1960 , to June 16, 1961 , that I last saw the deceased alive on June 16, 1961 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Eanet				ADDRESS (Street, city or town, state) 6727-16th St. N.W.			
PHYSICIAN'S NAME (Type) PAUL EANET M.D.				DATE SIGNED 6-16-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/61		22c. NAME OF CEMETERY OR CREMATORY Rose of Sharon		22d. LOCATION (City, town, or county) (State) Georgia Ave. S.W. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home				ADDRESS 5193 Wisconsin Ave. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 21 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 223 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS P.O. Box 76				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elaine Middle Marie Last Hessey						4. DATE OF DEATH Month June 11, Day 19 Year 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1946		9. AGE (In years last birthday) 14 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Hessey						14. MOTHER'S MAIDEN NAME Gladys Biggs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE MYELOGENOUS LEUKEMIA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 HRS 18 MOS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from October 31, 1960 to June 11, 1961 , that (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 1:15AM from the causes and on the date stated above.											
22a. SIGNATURE Emanuel S. Hellman M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6/11/61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Emanuel S. Hellman, M.D.						22d. ADDRESS The Clinical Center Bethesda 14, National Institutes Of Health, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME						ADDRESS Elkton, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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CERTIFICATE OF DEATH

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(M)

Decedent's Name: [Illegible]
Date of Birth: [Illegible]
Place of Birth: [Illegible]
Sex: [Illegible]
Race: [Illegible]
Marital Status: [Illegible]
Occupation: [Illegible]
Cause of Death: [Illegible]
Date of Death: [Illegible]
Place of Death: [Illegible]
Signature of Physician: [Illegible]
Signature of Registrar: [Illegible]

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[Illegible text block containing additional details and signatures]

Witnesses: [Illegible]
Registrar: [Illegible]
Date: [Illegible]
Place: [Illegible]

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information regarding the death. Pages 3 and 4 should be filled with information regarding the burial or cremation. Pages 5 and 6 should be filled with information regarding the funeral or memorial service. Pages 7 and 8 should be filled with information regarding the disposition of the remains. Pages 9 and 10 should be filled with information regarding the disposition of the remains.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6944

06931

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret, Middle Elgar Last Hill		4. DATE OF DEATH Month June Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1908
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 2 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S. A.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Messiah Addison		14. MOTHER'S MAIDEN NAME Annie Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 191.5	
17. INFORMANT Hospital Records		Address Olney Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pathological Fracture - Vertebrae - pubis 191.5 DUE TO Epidermoid Carcinoma Grade II Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anal-rectal Region - metastatic DUE TO (b) 1 1/2 DUE TO (c) 2 1/2		INTERVAL BETWEEN ONSET AND DEATH 2 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/21 to 6/26 , that (I) (we) last saw the deceased alive on 6/26 , and that death occurred at 6:25 PM from the causes and on the date stated above.		22a. SIGNATURE C. H. LIGON, M. D.,	
22b. DATE SIGNED 6/27/61		22c. PHYSICIAN'S NAME (Type) SANDY SPRING, MARYLAND	
22d. ADDRESS 6/27/61		22e. ADDRESS 6/27/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion,		23d. LOCATION (City, town, or county) (State) Mt. Zion, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swenden		25a. REC'D BY REGISTRAR JUN 30 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1883

CERTIFICATE OF DEATH

1883

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Attest, Notary Public

Notary Public

Notary Public

Notary Public

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6945

CERTIFICATE OF DEATH

Reg. Dist. No. 06932

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS 9709 E. Bexhill Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael First Holland Middle Holland Last		4. DATE OF DEATH June Month 17 Day 1961 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1880
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 9 Days 15	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A. Naturalized.	
13. FATHER'S NAME John Holland		14. MOTHER'S MAIDEN NAME Margaret Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Daughter Address Same as Item #2		17. INFORMANT Mrs. Howard H. Cork	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis + Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/27, 1960 , to present , that I last saw the deceased alive on 6/16, 1961 , and that death occurred at 8:15 AM , from the causes and on the date stated above.			
21. I certify that I attended the deceased from 12/27, 1960 , to present , that I last saw the deceased alive on 6/16, 1961 , and that death occurred at 8:15 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8805 Conn. Ave. C/1761 DATE SIGNED Chery Chase 15 PM	
ACTUAL SIGNATURE John B. Umhau M.D.		PHYSICIAN'S NAME (Type) JOHN B. UMHAU	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-17-61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Yeadon, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE JUN 21 '61	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6807 Randolph St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Henry HOOPER		4. DATE OF DEATH Month June Day 9 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept.	9. AGE (In years last birthday) 61 yrs.
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. HOOPER		14. MOTHER'S MAIDEN NAME Rosa REECE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 577-46-7333	
17. INFORMANT (S) Raymond E. Hooper, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia and Chronic Emphysema. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 2 1961 to June 9 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 9 1961 , and that death occurred at 1:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Linaweaver, LT, MC, USN		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-13-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, 131 11th St., SE, WashDC		25a. REC'D BY REGISTRAR JUN 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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11. *How do you feel about the way the company is run?*

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D.C. 44-38861-100

WILLIAM H. ROOPER

Figure 1

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Abstract

Information available

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 3906 Glenhunt Road			
3. NAME OF DECEASED (Type or print) First Michael Middle Joseph Last HOPKINS				4. DATE OF DEATH Month June Day 8 Year 19 61			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-59	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Kenneth Gilman HOPKINS				14. MOTHER'S MAIDEN NAME Patricia Helen FEEHLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Kenneth G. Hopkins, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.1 Congenital Heart disease (single ventricle, DUE TO (b) patent ductus arteriosus and pulmonary stenosis with, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) transposition of great vessels)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 4 to June 8 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 8 , 19 61 , and that death occurred at 11:31 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. E. McClenathan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-12-61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City, town or county) Baltimore	(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home, 5303 Harford Rd.				25a. REC'D BY REGISTRAR DATE JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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1921-22

• 2014, 2015, 2016

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6948

06935

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Brookville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>			d. STREET ADDRESS <u>Box 72 - Rt. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Samuel Howard</u>			4. DATE OF DEATH Month Day Year <u>JUNE 10 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1896</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State; foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GREENBURY Howard</u>			14. MOTHER'S MAIDEN NAME <u>REBECCA Nettles</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stonewall ave. Rockville, Md. Harriet C. Jenkins (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small Intestinal obstruction (ileus)</u> 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Valvular & Small Bowel Mesentery</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> 19 <u>61</u> to <u>6/10</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> 19 <u>61</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Arthur F. Woodward</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rockville - Md.</u>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/14/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery,</u>		23d. LOCATION (City, town or county) (State) <u>Unity, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Sworick</u>		ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8893

8893



Handwritten text, possibly a signature or name, appearing in the center of the page.

Robert H. Woodcock
Family Cemetery
1911

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6949

06936

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>1225 Missouri Ave NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dora Inoff</u>		First Middle Last		DATE OF DEATH <u>June 1 1961</u>		Day Month Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1881</u>	9. AGE in years (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>H. Crenshaw</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Nursing Home Record</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular accident</u> (c) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1/2 day</u> <u>2 wks</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip at home about 3 m. ago</u></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u></p> </div> <div> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> </div> <div> <p>DATE SIGNED <u>6-1-61</u></p> </div> </div>							
22b. DATE THEREOF <u>6/2/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Capital Hebrew Cem.</u>		22d. LOCATION (City, town, or country) <u>D.C.</u>		(State) _____	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		ADDRESS <u>4217 9th Street N.W.</u>		24e. REC'D BY REGISTRAR <u>JUN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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1915. General Hospital, D.C.

1915. General Hospital, D.C.

1915. General Hospital, D.C.

1915. General Hospital, D.C.

1915. General Hospital, D.C.

2530

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

Item 18 Film 290 7-3-61											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06938											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Chevy Chase</u>					
c. LENGTH OF STAY IN 1b <u>5 days</u>						d. STREET ADDRESS <u>4706 Hunt Avenue</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Salyer Jennings</u>						4. DATE OF DEATH Month Day Year <u>June 19 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. News & World Report</u>		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles Jennings</u>						14. MOTHER'S MAIDEN NAME <u>Jane Salyer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>Unknown</u>					
17. INFORMANT <u>Pauline Jennings (wife)</u>						Address <u>Same as above</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Spontaneous thrombosis of pulmonary, coronary & cerebral arteries</u>											
902.0 DUE TO (b) <u>Acute Thrombocytosis following splenectomy</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>rupture of spleen from accidental fall</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from house roof at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6-18 1961</u>						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Chevy Chase Montg. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>6-19-61</u>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.											
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/22/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>											
24a. REC'D BY REGISTRAR <u>JUN 22 '61</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kress</u>					

(M)

(1)

Montgomery
Baltimore
Baltimore

Male white

Editor

Charles Tennings

Mr

William Pauline Tennings (wife)

U.S. Government Light Colorado

Nov. 24, 1912

Charles & Ralph Tennings

1300 Hunt Avenue

June 19 1911

Blackland

Chief Clerk

Montgomery

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6952

06939

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 16 HOURS		a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 15500 GOOD HOPE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARGARET Middle REBECCA Last JOHNSON				4. DATE OF DEATH Month JUNE Day 13 Year 19 61				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-82		
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Jackson JACK HAROING				14. MOTHER'S MAIDEN NAME Rebecca Myers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-34-8156		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PERITONITIS DUE TO PERFORATION OF COMMON DUCT Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. HYPERTENSIVE HEART DISEASE (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 DEC. 1960 to 13 JUNE 19 61 , that (I) (we) last saw the deceased alive on 13 June 19 61 and that death occurred at 11 P.M. from the causes and on the date stated above.								
22a. SIGNATURE John Bosley Ziegler				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/61		
22c. PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER, M. D.,				22d. ADDRESS OLNEY, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/61		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery		23d. LOCATION (City, town, or county) (State) Burtonsville, Montgomery, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR DATE JUN 16 '61		
				25b. REGISTRAR'S SIGNATURE William E. Hines				

(I)

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EP

22882

22882

CERTIFICATE OF DEATH

HUSBAND

WIFE

CHILD

DECEASED

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

AGE

SEX

RACE

RELIGION

EDUCATION

TO

FROM

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6953

06940

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>17</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6631 Eastern Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>MARIE</u> Last <u>Jokumsen</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-10-72</u>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Service</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mads Jokumsen</u>			14. MOTHER'S MAIDEN NAME <u>Karen Maria Nelson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CONGESTIVE HEART FAILURE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>17 JUNE, 1961</u> , to <u>27 JUNE, 1961</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>26 JUNE, 1961</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morrill C. Quinnan Jr.</u> M.D.				22b. DATE SIGNED <u>6-27-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAN, JR.</u>				22d. ADDRESS <u>704 Northshore Road Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 29, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>			
23d. LOCATION (City, town or county) <u>Washington</u>		(State) <u>D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				25a. REC'D BY REGISTRAR <u> </u>			
25b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>JUN 30 '61</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06941

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First Betty Middle A. Last Jones				4. DATE OF DEATH Month 6 Day 13 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/02		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hammond				14. MOTHER'S MAIDEN NAME Gilly Ann Helton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Henry B. Jones / same As Above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 6/8 to 6/13 19 61 that (he) last saw the deceased alive on 6/13 19 61 and that death occurred at home from the causes and on the date stated above.							
22a. SIGNATURE H.C. Maganzini				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/61	
22c. PHYSICIAN'S NAME (Type) H.C. Maganzini				22d. ADDRESS 509 Keirshurst Rd, Rockville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/15/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town, or county) (State) Rockville, Montgomery, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 E. Montg. Ave Rockville, Maryland		25a. REC'D BY REGISTRAR DATE JUN 19 61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6955

06942

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Hosp. & Sant.				d. STREET ADDRESS 1519--White Pl., S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAURA Middle PECK Last JONES		4. DATE OF DEATH Month June Day 1st Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Boarding Home		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Galusha A. Peck				14. MOTHER'S MAIDEN NAME Susan Mertz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Frank S. Peck 1519--White Pl SE Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large bed sores, malnutrition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland, Md.	(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 26, 1961 to June 1, 1961 , that (we) last saw the deceased alive on June 1, 1961 , and that death occurred at 4:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Norman H. Rubenstein		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS 6480 N.H. Ave. Takoma Park, Md.			
22c. PHYSICIAN'S NAME (Type) Norman H. Rubenstein, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 3, 1961	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Simon Bros.		ADDRESS 1661--Good Hope Rd., SE Washington 20 DC		25a. REC'D BY REGISTRAR DATE JUN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

1355

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF RELIGION
SIGNATURE OF JURY
SIGNATURE OF CORONER

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TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66944

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1868 Columbia Rd. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ola Elizabeth		4. DATE OF DEATH Last June 3 1961		5. SEX Fe		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-86		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME William F. Morris		14. MOTHER'S MAIDEN NAME Letitia Longfellow		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-16-2933	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure (Acute Decompensation) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular-Renal Syndrome DUE TO (c) 1 Day PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Varicose ulcer - Right lower leg		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from May 1, 1961 to June 3, 1961 , that (I) (we) last saw the deceased alive on June 2, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Lynwood Heiges M.D.	
22b. DATE SIGNED June 3, 1961		22c. PHYSICIAN'S NAME (Type) LYNWOOD HEIGES, M.D.		22d. ADDRESS 6940 Emily Branch Rd. N.W.		22e. REC'D BY REGISTRAR June 3, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/5/61		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		ADDRESS Wash, D.C.		25a. REC'D BY REGISTRAR JUN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06945

6957

1. PLACE OF DEATH a. COUNTY: <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE: <u>D.C.</u> b. COUNTY: <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): <u>Washington</u>			
c. LENGTH OF STAY IN 1b: <u>7 1/2 days</u>				d. STREET ADDRESS: <u>6641 32nd Street N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): <u>Suburban Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: <u>Annie</u> Middle: <u>Malkin</u> Last: <u>Joyce</u>				4. DATE OF DEATH Month: <u>June</u> Day: <u>20</u> Year: <u>1961</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: <u>Dec 9 1871</u>	
9. AGE (In years last birthday): <u>89</u> yrs.		IF UNDER 1 YEAR: Months: <u> </u> Days: <u> </u>		IF UNDER 24 HRS.: Hours: <u> </u> Min.: <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u> </u>		11. BIRTHPLACE (County & State, or foreign country): <u>Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY?: <u>USA.</u>							
13. FATHER'S NAME: <u>Joseph Malkin</u>				14. MOTHER'S MAIDEN NAME: <u>Emily Cady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.: <u> </u>		17. INFORMANT: <u>James Wallace Joyce (Son)</u> Address: <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1961</u> to <u>June 20, 1961</u> that (I) (we) last saw the deceased alive on <u>June 19, 1961</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE: <u>R. Raedy</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED: <u>June 20 1961</u>	
22c. PHYSICIAN'S NAME (Type): <u>R. Raedy M.D.</u>				22d. ADDRESS: <u>3701 Leland ST Chevy Chase Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		23b. DATE THEREOF: <u>6-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State): <u>Prince George Co., Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE: <u>ROBERT A. PUMPHREY</u> ADDRESS: <u>Bethesda, Md.</u>				25a. REC'D BY REGISTRAR: <u>JUN 22 '61</u>		25b. REGISTRAR'S SIGNATURE: <u>Arthur S. Hume</u>	

1. TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Robert A. Dierker
Lecturer, M.
Geddes Hill Observatory
Lecture George Co., Mo.

Robert A. Dierker
Lecturer, M.
Geddes Hill Observatory
Lecture George Co., Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6958

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06946

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4019 5th St. N. W.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>James Wilson Kendall</u>		4. DATE OF DEATH <u>June 27 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-86</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman - Streetcar</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Robert Buchanan Kendall</u>				14. MOTHER'S M maiden name <u>Isadora Brown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-10-6246</u>				17. INFORMANT <u>Margaret E. Kendall</u> same 2-d Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Congestive heart failure</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>10 yrs.</u> <u>10 yrs.</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 1961, to <u>June 27</u> , 1961, that (I) (we) last saw the deceased alive on <u>June 26</u> , 1961, and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>A.W. Smith</u>				22b. DATE SIGNED <u>6/27/61</u>				22c. PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>				22d. ADDRESS <u>13018 GEORGIA AVE WHEATON, MD.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/30/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>JUN 29 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Hines Co. Washington, D. C.</u>																							

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the O. H. Hines Co. Washington, D. C.
Burial 63045 Glenwood Cemetery Washington, D. C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

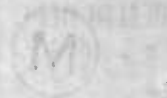
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FOR STATE
HEALTH DEPT.
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06947

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring</u>		d. STREET ADDRESS <u>1021 Forest Glen Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1021 Forest Glen Rd</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Elizabeth Kesler</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARITAL STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7-12-1894</u>		9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Bey. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. Graham</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-10-9688A Wm</u>	
17. INFORMANT <u>Eliz. Kesler</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchitis</u> DUE TO (c) <u>gum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaut</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaut</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>6-15-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		22d. LOCATION (City, town, or country) (State) <u>UNION BRIDGE MD</u>	
23. FUNERAL DIRECTOR <u>DD Hartzler & Sons</u>				ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>JUN 19 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			



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FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06948

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg c. LENGTH OF STAY IN 1b Clarksburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Johnson Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg d. STREET ADDRESS Johnson Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Brewer John King		4. DATE OF DEATH June 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1890
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (State or foreign country) Montg. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John B. King	
14. MOTHER'S MAIDEN NAME Lillie Burns		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW # 1	
16. SOCIAL SECURITY NO. 212-14-5755		17. INFORMANT Mrs Elizabeth P. King Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 23, 1961			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF June 27, 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or country) Fort Myer, Va.		24a. REC'D BY REGISTRAR DATE JUN 27 '61	
24b. REGISTRAR'S SIGNATURE Olin L. Molsworth		24c. REGISTRAR'S SIGNATURE Damascus, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06949

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9703 Beall Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Damascus d. STREET ADDRESS 9703 Beall Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Barton Last Klawonn		4. DATE OF DEATH Month June Day 9 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Fulton Co., Pa.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Samuel Slayman		14. MOTHER'S MAIDEN NAME Mary Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-4711		INFORMANT Mrs Harry B. Merson, Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 Anteroseptotic cardiovascular disease DUE TO (b) 10 yrs. DUE TO (c) 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18 , 19 58 , to 6/9 , 19 61 , that I last saw the deceased alive on 6/9 , 19 61 , and that death occurred at M , from the causes and on the date stated above.					
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 6/9/61	
PHYSICIAN'S NAME (Type) James P. Kerr					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1961		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
22d. LOCATION (City, town, or county) Prince Georges Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. W. Johnson		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR JUN 13 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

(M)

Montgomery

Montgomery

Danvers

Danvers

2701 Tenth Ave.

2701 Tenth Ave.

Myrtle

Myrtle

Martha White

Martha White

Montgomery

Montgomery

Samuel Glynn

Samuel Glynn

no

200-07-4111 Mrs. Harry A. Gordon

1950

Interstate Telephone

James T. Kelly

James T. Kelly

April 12, 1951

Fort Lincoln

James Gordon Co., Inc.

Danvers, MA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6962											
06950											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 10 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp.				d. STREET ADDRESS 9407 Biltmore Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick Joseph Klund				4. DATE OF DEATH Month June Day 8 Year 1961							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-87		9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Internal Revenue				11. BIRTHPLACE (County & State, or foreign country) Delaware			
12. CITIZEN OF WHAT COUNTRY? Amer.				13. FATHER'S NAME David H. Klund				14. MOTHER'S MAIDEN NAME Georganna Joseph			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction and severe pulmonary edema DUE TO left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive heart disease with left ventricular hypertrophy DUE TO Right lung, upper lobe, early acute bronchopneumonia (c) Six days postoperative for resection of adenocarcinoma of the colon										INTERVAL BETWEEN ONSET AND DEATH days years days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) May				20g. (County) June 7, 1961				20h. (State) June 7, 1961			
21. I certify that (I) (this hospital) attended the deceased from May 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE George H. McLean				22b. DATE SIGNED June 8-61							
22c. PHYSICIAN'S NAME (Type) GEORGE H. MCLAIN				22d. ADDRESS 1746 K St. N.W. Wash - D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/12/61				23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery, Suitland, Prince George's			
23d. LOCATION (City, town or county) Maryland				23e. REC'D BY REGISTRAR June 14 '61				23f. REGISTRAR'S SIGNATURE Arthur S. Frank			
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue				24a. ADDRESS Silver Spring, Maryland							

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76. [illegible]
77. [illegible]
78. [illegible]
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96. [illegible]
97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

10

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6964 06952											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b 13 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 16916 Cashell Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Herman Henry Ladson						4. DATE OF DEATH June 14 1961					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days 14 19 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian						11. BIRTHPLACE (County & State, or foreign country) District of Columbia U.S.A.					
13. FATHER'S NAME Thomas A. Ladson						14. MOTHER'S MAIDEN NAME Alice Yoss					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 5271					
17. INFORMANT Washington Sanitarium and Hospital Records						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary failure, 5271 DUE TO Severe R & L heart strain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Severe Pulmonary Embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death about 2 months											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/18/61 to 6/14/61 , 19 61 , that (I) (we) last saw the deceased alive on 6/13/61 , 19 61 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W. H. Holohan M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) W. H. Holohan, M.D.						22d. ADDRESS 7401 Blue Rd. N.W. Wash D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-16-61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis W. Barber						ADDRESS Laytonsville, Md.			25a. REC'D BY REGISTRAR JUN 19 1961		
									25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

(M)

Montgomery
Takoma Park

Washington Sanitarium and Hospital 1616 Cassell Road

Hermon X Henry Lodson June 14 1911

Male White May 22, 1888 23

Veterinarian District of Columbia U.S.A.

Thomas A. Lodson Alice Yoss

Washington Sanitarium and Hospital 1616 Cassell Road

Washington, D.C. Lockport, New York

Washington, D.C. Lockport, New York

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6965

06953

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8718 CAMERON STREET apt. 218		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8718 CAMERON STREET apt. 218 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILDRED PEABODY LAIRD First Middle Last		4. DATE OF DEATH JUNE 24 1961 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 8, 1934
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) DANVERS, MASS.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE H. PEABODY		14. MOTHER'S MAIDEN NAME AUGUSTA MUDGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 013-20-1060 B	
17. INFORMANT Robert P. Laird, West Vancouver, Canada Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure of heart DUE TO (b) Multiple, widespread metastatic malignancy DUE TO (c) Mixed mesodermal tumor of uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6-8 weeks 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1960 , to June 24, 1961 , that (I) (was) last saw the deceased alive on 24 June 1961 , and that death occurred at 1:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Ernest E. Harmon ERNEST E. HARMON (Type) NAME (Type)		22b. DATE SIGNED JUNE 24, 1961	22c. ADDRESS 9301 Colesville Rd Silver Spr. Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF JUNE 24, 1961	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY
23d. LOCATION (City, town or county) PRINCE GEORGE'S COUNTY MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Ziska ADDRESS PUMPHREY, INC., SILVER SPRING, MD.		25a. REC'D BY REGISTRAR JUN 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Haines

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1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 26

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6966
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06954

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
c. LENGTH OF STAY IN 1b 67 days				d. STREET ADDRESS R.F.D. 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Lammers				4. DATE OF DEATH Month June Day 12 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1896	
9. AGE (In years lost birthday) 65 yrs.		10. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 12 Min.		IF UNDER 24 HRS. Months 6 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck body builder				10b. KIND OF BUSINESS OR INDUSTRY Truck manufacturing			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Lammers				14. MOTHER'S MAIDEN NAME Annie Otten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unavailable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disseminated Carcinoma of (c) Unknown primary site INTERVAL BETWEEN ONSET AND DEATH 2 days 4 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 6, 1961 to June 12, 1961 , that (I) (we) last saw the deceased alive on June 12, 1961 , and that death occurred 3:00AM from the causes and on the date stated above.							
22a. SIGNATURE Walter Oppelt				22b. DATE SIGNED 6-12-61			
22c. PHYSICIAN'S NAME (Type) WALTER OPPELT, M.D.				22d. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial June 15, 1961				23b. DATE THEREOF June 15, 1961			
23c. NAME OF CEMETERY OR CREMATORY St Marys Cem				23d. LOCATION (City, town, or county) (State) Laurel Md			
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Connelton				25a. REC'D BY REGISTRAR DATE JUN 19 '61			
25b. REGISTRAR'S SIGNATURE Charles S. Fenn							

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CERTIFICATE OF DEATH

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Person deceased

Married

Married

Age

of days

Residence

1900

The Clinical Center, Bethesda, Md.

1900

John Henry

White

1900

Black body

Married

Henry Lawrence

Single

The Clinical Center, Bethesda, Md.

June 12, 1901

June 12, 1901

June 12, 1901

The Clinical Center, National Institution of Health, Bethesda, Md.

June 12, 1901

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06955

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in lb 11 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spr ng		d. STREET ADDRESS 9824 Woodland Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp.				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Theresa Grace Langbein				4. DATE OF DEATH Month Day Year June 27 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1874		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cashier (ret)		10b. KIND OF BUSINESS OR INDUSTRY Dept. store, D.C.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. A. Langbein				14. MOTHER'S MAIDEN NAME Josphine Getz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 577-05-3579		17. INFORMANT Hosp. Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Thrombosis, left descending coronary DUE TO (c) Atherosclerosis, coronary						INTERVAL BETWEEN ONSET AND DEATH 36 hours 36 hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture rt. hip with malunion 16-18 June '61						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home fracturing rt. hip					
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. 6/16/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Silver Spring Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/27/61	
EXAMINER'S NAME (Type) Frank J. Broschart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-61		22c. NAME OF CEMETERY OR CREMATORY mt hillier cemetery		22d. LOCATION (City, town, or country) (State) Washington D.C.	
23. FUNERAL DIRECTOR F. J. Collins		ADDRESS 3821-14th NW D.C.		24a. REC'D BY REGISTRAR 30 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3936

MEDICAL EXAMINER CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Silver Spring, Md.		35		Male		White		June 23, 1961		Silver Spring, Md.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Heart failure		Natural		None		High School		Married		Middle Class	
Contributing Factors		Medical History		Family History		Previous Illnesses		Recent Events		Other Notes	
Hypertension		None		None		None		None		None	
Diagnosis		Prognosis		Treatment		Response		Disposition		Remarks	
Myocardial infarction		Poor		Medical		None		Home		None	
Autopsy		Postmortem		Toxicology		Microbiology		Histology		Other	
None		None		None		None		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

<div> <div> <div>18&21</div> <div>29-61</div> <div>ams</div> </div> <div> <div>9-27-61</div> <div>6968</div> </div> </div> <div> <div>Items</div> <div>File</div> <div>296</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>06956</div>																	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Roma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keenington</u> d. STREET ADDRESS <u>1105 Lind Pl</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>David Reed La Roche</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-21-58</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Ronald P. La Roche</u>								14. MOTHER'S MAIDEN NAME <u>Erma Bort</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Ronald P. LaRoche-Father-same 2d</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Early Acute interstitial pneumonia</u> 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PENDING</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6-14-61</u>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>									
23. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>JUN 16 '61</u>									

MEDICAL CERTIFICATION

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(M)

(1)



CERTIFICATE OF DEATH

Reg. Dist. No. 06957

6969

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>20 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM + Hospital</u>				d. STREET ADDRESS <u>714 Bennington Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA Elizabeth LAWSON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 25 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-86</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Clarion, Penn. Amer.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Clarence Myers</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>175-059444</u> Copied from chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Smoked Arteriosclerosis</u> DUE TO (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>61</u> , to <u>June 25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>927 Rushing Dr Silver Spring Md</u>				DATE SIGNED <u>6-25-61</u>			
ACTUAL SIGNATURE <u>Abraham W D Anish</u>				M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>ABRAHAM W D ANISH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>WILKINSBURG, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Collins</u> ADDRESS <u>3821-14th ST. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6970

06958

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> c. LENGTH OF STAY IN 1b <i>Seven years</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home, 3100 Jennings Rd.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> d. STREET ADDRESS <i>3100 Jennings Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Antonio</i> Middle <i>NMI</i> Last <i>Lopes</i>		4. DATE OF DEATH Month <i>June</i> Day <i>27</i> Year <i>1961</i>					
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 1, 1880</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months <i>81</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>			
13. FATHER'S NAME <i>Salvatore Lopes</i>			14. MOTHER'S MAIDEN NAME <i>Antoinette Samperi's</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-28-4261</i>		17. INFORMANT <i>Joseph Lopes</i> Address <i>3100 Jennings Rd., Kensington</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Multiple Myeloma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old Fracture, left hip</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>6 months</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 5, 1960</i> to <i>June 27, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 24, 1961</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>John C. K. Yu</i>		22b. DATE SIGNED <i>June 27, 61</i>					
22c. PHYSICIAN'S NAME (Type) <i>John C. K. Yu</i>		22d. ADDRESS <i>4912 Adrian St., Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/1/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>			
				23d. LOCATION (City, town or county) (State) <i>Montgomery County, Maryland</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>				25a. REC'D BY REGISTRAR <i>DATE JUL 5 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Caroline S. Hanna</i>							

VR A15 (4)
15M 9/60

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6971

08214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Boyds</u> d. STREET ADDRESS <u>Route #2 Box 205</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>BABY GIRL "A" LYLES</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-2-61</u>		9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Alfred Dome</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mae Lyles</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>June 3, 1961</u> , to <u>June 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>M. H. Grosvenor</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>MABEL H. GROSVENOR, M.D.</u>				22d. ADDRESS <u>2203 WYOMING, N.W., WASH., D.C.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>7-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>OLD GEORGETOWN RD. BETHESDA, MARYLAND</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER - ADM. - (per F.B.)</u>				ADDRESS <u>SUBURBAN HOSPITAL BETHESDA, MD.</u>				25a. REC'D BY REGISTRAR <u>JUL 13 61</u>		25b. REGISTRAR'S SIGNATURE <u>C. H. ...</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08215

Items 11 & 12 from Birth Certif.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Route #2 Box 205 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl "B" Hyles</u>		4. DATE OF DEATH Month Day Year <u>June 3 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-61</u>
9. AGE (In years lost birthday) <u>- yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alfred Dome</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mae Sykes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 2</u> 19 <u>61</u> , to <u>June 3</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Grosvenor</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. GROSVENOR, M.D.</u>		22d. ADDRESS <u>2203 WYOMING, N.W., WASH., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>7-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN ROAD, BETHESDA, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia Carter - Adm. - (per 915.)</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
ADDRESS <u>SUBURBAN HOSPITAL, BETHESDA, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Pinner</u>	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2274203XV0

RECEIVED IN THE DEPARTMENT OF HEALTH

WASHINGTON, D. C. 20540

STATE OF DEATH

ST 10

(M)

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(M)

(M)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Page 4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6973

CERTIFICATE OF DEATH

Reg. Dist. No. 06959

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1, Monrovia				d. STREET ADDRESS RFD # 1, Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle -- Last Lyles		4. DATE OF DEATH Month June Day 12 Year 1961					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 65	IF UNDER 24 HRS. Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lewisdale, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vatchel Lyles				14. MOTHER'S MAIDEN NAME Clarsia Zigler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		INFORMANT Mrs Edna Lyles, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with generalized metastases 177X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14 , 19 47 to 6/12 , 19 61 that I last saw the deceased alive on 6/11 , 19 61 , and that death occurred at 4A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 6/12/61 ACTUAL SIGNATURE James P. Kerr M.D. Damascus, Md. PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1961		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Purdim, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McPherson				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 14 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

100-10000

CERTIFICATE OF DEATH

1073

Montgomery

Montgomery

Montgomery

Burial - Louisiana

Life

Burial - Louisiana

RD 1, Louisiana

RD 1, Louisiana

Life

Life

Nov. 12, 1902

Nov. 12, 1902

Louisiana, La.

Louisiana, La.

Clara M. Miller

Clara M. Miller

Mrs. John Miller, Dec. 2

Mrs. John Miller, Dec. 2

100-10000

Dec. 1, 1902

Dec. 1, 1902

Dec. 1, 1902

Dec. 1, 1902

Dec. 1, 1902

Dec. 1, 1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

6974

06960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3506 Raymond Street</u> <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>A.</u> Last <u>Lynch</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-07</u>
9. AGE (In years last birthday) yrs. <u>53</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Farrell Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Christina Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Thomas J. Lynch</u> Address <u>3506 Raymond St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810 Hepatic Cirrhosis</u> DUE TO <u>Curbing of liver</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Curbing of liver</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>61</u> , to <u>6-11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-11</u> , 19 <u>61</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>James A. Bailey</u> M.D.		ADDRESS (Street, city or town, state) <u>Wash. An. Clinic, Wash. DC</u> DATE SIGNED <u>6-12-61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemeter</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>	
ADDRESS <u>3821-14th St. N.W. Wash. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruze</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

Blank form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6975

06961

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 1044 26th Road S. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Joseph Middle Bertram Last LYNCH </div>			4. DATE OF DEATH Month June Day 27 Year 19 61				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3-11-93		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Massachusetts			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edward LYNCH				14. MOTHER'S MAIDEN NAME Mary E. CARTY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, right cerebral hemisphere DUE TO (b) Atherosclerosis, generalized Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 8 hours Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) June 26, 1961		20g. (County) 2:40PM		20h. (State) June 27, 1961			
21. I certify that He (his hospital) attended the deceased from June 26, 1961 to June 27, 1961 , that he (we) last saw the deceased alive on June 27, 1961 , and that death occurred at 2:40PM , from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 6-28-61			
22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR., CAPT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR DATE JUN 30 '61			
25b. REGISTRAR'S SIGNATURE 				25c. ADDRESS JOS. GAWLERS & SONS, 1756 Penna. Ave., NW, WashDC			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

Residence (Home)

U. S. Naval Hospital

Joseph

Bartram

LYNCH

June 27

21

Male

Communication

XXXXX

1-11-23

on

Captain

U. S. Navy

Massachusetts

USA

Edward LYNCH

Mary L. O'FAY

Yes

Hospital Record

Homeless, right hand and foot

radical, excised

Yours

Burial

1-10-21

Washington National

Armed Forces

Virginia

JOE. LAWREN & SONS, 1750 Penna. Ave., NW, Wash DC

June 27

G. I. WARRER, JR., CAPT, USN, U. S. Naval Hospital, Bethesda, Md.

1-28-21

June 27

June 28 2:40 PM

June 27

2

TO HOSPITAL OR A DURING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
6978
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06962

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Kearneysville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle Thelma Last Macoughtry		4. DATE OF DEATH Month June Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1908
9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR Months 52 Days 11 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Heaton		14. MOTHER'S MAIDEN NAME Amelia Tagg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 23 , 19 61 , to June 11 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 11 , 19 61 , and that death occurred at 4:10PM from the causes and on the date stated above.			
22a. SIGNATURE Benjamin A Borowsky		22b. DATE 6/12/61	
22c. PHYSICIAN'S NAME (Type) BENJAMIN A. BOROWSKY, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans 6/12/61		23b. DATE THEREOF 6/12/61	
23c. NAME OF CEMETERY OR CREMATORY Episcopal Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JUN 13 '61	

(M)

West Virginia

Montgomery

Leavenworth

Bedford

R. D. # 1

The Clinical Center, Bedford, Pa., Pa.

June 11

June

Montgomery

Thames

Caroline

September 5, 1908 52

x

White

Female

Hennepin

Hennepin

Hennepin

Little Rock

William L. Heston

The Clinical Center, Bedford, Pa., Pa.

Hennepin

No

Statistical Department of Heston

2 years

(1)

June 11

June 11

May 29

4:10 PM

51

June 11

x

4/12/01

The Clinical Center, Heston
Investigates of Heston, Bedford, Pa., Pa.

WILLIAM L. HESTON, M.D.

Bedford, Pa., Pa.

Statistical Department

Robert A. Heston, Bedford, Pa., Pa.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6977

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06963

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d. STREET ADDRESS 110701 MacArthur Boulevard			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nettie Middle M. Last Marsden				4. DATE OF DEATH Month June Day 28 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME J. Theodore Hill				14. MOTHER'S MAIDEN NAME Emsey Henderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (S) Robert B. Marsden, Chevy Chase Drive, 4820 Chevy Chase Drive, Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Cardiovascular Disease DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 19 58 to June 28, 19 61 , that (I) was lost saw the deceased alive on 27 June 19 61 , and that death occurred on 28 M, from the causes and on the date stated above.							
22a. SIGNATURE W. F. Cresswell, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/28/61	
22c. PHYSICIAN'S NAME (Type) W. F. Cresswell, Jr.				22d. ADDRESS 2029 Que St. NW, Wash. D. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/61		23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		23d. LOCATION (City, town, or county) (State) Potomac, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 6 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

1. Name of deceased: *Robert A. Kennedy*
2. Date of death: *June 25, 1963*
3. Place of death: *Washington, D.C.*
4. Age: *36 years*
5. Sex: *Male*
6. Race: *White*
7. Cause of death: *Assassination*
8. Manner of death: *Violent*
9. Signature of physician: *John Edgar Hoover*
10. Signature of registrar: *Robert A. Kennedy*
11. Date of registration: *June 26, 1963*
12. Place of registration: *Washington, D.C.*

TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6978

CERTIFICATE OF DEATH

Reg. Dist. No. 06964

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 09			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 838 Rockville Pike				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbert Middle A Last MARTH				4. DATE OF DEATH Month June Day 8 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1909	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 3 Days 13		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio repairman				10b. KIND OF BUSINESS OR INDUSTRY Radio		11. BIRTHPLACE (State or foreign country) Germantown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William G. Marth				14. MOTHER'S MAIDEN NAME Ada Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown-yes			
17. INFORMANT Gertrude M. Marth-wife-same				Address Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular hypertensive disease DUE TO (c) Cirrhosis of liver, with jaundice & ascites PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - 5 years							
INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years 1 year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 8, 1960 to June 8, 1961 , that I last saw the deceased alive on June 7, 1961 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Linthicum M.D. 1105 Washington St.				DATE SIGNED June 8, 1961			
PHYSICIAN'S NAME (Type) W. A. Linthicum				Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/1961		22c. NAME OF CEMETERY OR CREMATORY Rockville Cem. Assn.		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR DATE JUN 9 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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1938

CERTIFICATE OF DEATH

1938

M

Montgomery

Hockville

Hockville

125 Hockville Ave

125 Hockville Ave

White

White

White

White

Radio repairman

Radio

William G. Martin

Aha Carter

Unknown - see Gertrude M. Martin - same last 12

1

2

Robert A. Thompson

Hockville, Md.

Hockville, Md.

Hockville

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6979

06965

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b Since 6/16/61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2733 Ordway Street, N. W. Apt. 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) Norma L. MASON		4. DATE OF DEATH Month June Day 10 Year 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1915		9. AGE (In years last birthday) 46 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>1</td> <td>1</td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	1	1		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																							
Months	Days	Hours	Min.																						
1	1																								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA																	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 8800 Bradmoor Drive Mrs. W. A. Sterba-Friend Bethesda, Maryland																					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial decompensation, DUE TO (b) Advanced Inanition, Dehydration, (c) Carcinomatosis, (Breast) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 1 Mo. 6 Yrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral Circulatory Failure										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)															
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>6-10-61</u>, that (I) (we) last saw the deceased alive on <u>6-9-61</u>, and that death occurred at <u>5:30 AM</u>, from the causes and on the date stated above.																									
22a. SIGNATURE James W. Long, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-10-61																	
22c. PHYSICIAN'S NAME (Type) James W. Long, M.D.						22d. ADDRESS 6601 Greentree Road, Bethesda, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 6-10-61		23c. NAME OF CEMETERY OR CREMATORY Hebbing Park Cemetery		23d. LOCATION (City, town or county) St. Louis County, Minn.		(State)																	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline																	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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(M)

Montgomery

District of Columbia

Beltsville

Since 8/16/61

Washington

Suburban Hospital

3733 Ordway Street, N.W. Apt. 6

Norona

MASON

June

10

61

Female

White

May 9, 1913

46

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Secretary

U.S. Government, Minnesota

USA

Unknown

Unknown

(I)

No

None

8800 Birdwood Drive
Mrs. W.A. Stepha-Rieder, Beltsville, Maryland

James W. Long, M.D.

5601 Greenview Road, Beltsville, Maryland

Ben-transit 6-10-61

Hobbs Park Cemetery, St. Louis County, Minn.

Robert A. Humphrey

Beltsville, Maryland

May 14 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6980

06966

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Grace M. McCrossin</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/78</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwf</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Darnestown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Edward S. Hunter</u>				14. MOTHER'S MAIDEN NAME <u>Anna Virginia Hunter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Bertha Myers Gaithersburg, Rt. 3 Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS WITH HEMIPLEGIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> <u>2 yr.</u> <u>2 wk.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 19 52</u> to <u>JUNE 17, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>JUNE 17 1961</u> , and that death occurred at <u>3:03</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo M. Curtis</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>				22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/ 20/ 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with the signature of the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

CERTIFICATE OF DEATH

1957

(M)

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6981

06967

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE New York b. COUNTY Long Island, Freeport c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Island, Freeport d. STREET ADDRESS 56 Elliott Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora First Helen Middle McDermott Last				4. DATE OF DEATH June Month 8, Day 19 61 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1915	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR 4 Months 16 Days		11. IF UNDER 24 HRS. 4 Hours 16 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Albert Haeffer				14. MOTHER'S MAIDEN NAME Josephine Englehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 410X IMMEDIATE CAUSE (a) Aortic stenosis, mitral stenosis DUE TO (b) Rheumatic fever Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) Pulmonary atelectasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary atelectasis INTERVAL BETWEEN ONSET AND DEATH 3 years 35 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15, 19 61 to June 8, 19 61 that (I) (we) last saw the deceased alive on June 8, 19 61 , and that death occurred at 2:25 PM from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Levine, M.D. M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-8-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert J. Levine M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 6/9/1961		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Middle Village New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR BUN 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6982

06968

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD3 Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD3, Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>McDonald</u> Middle <u>McDonald</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		IF UNDER 24 HRS. Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Mc Donald</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Helen M. McDonald, Wife, RD3 Gaithersburg</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Varicose ulcer Lt. lower leg</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from <u>7-6</u> 19 <u>60</u> to <u>6-5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-6</u> 19 <u>60</u> , and that death occurred on <u>6-5</u> 19 <u>61</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Oliver J. Jackson,</u>				22b. DATE SIGNED <u>6-9-61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>202 Martin Lay, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/8/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul.,</u>				23d. LOCATION (City, town, or county) (State) <u>Sugarland, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				25a. REC'D BY REGISTRAR <u>Robert L. Snowden</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>JUN 20 '61</u>			

10000

10000

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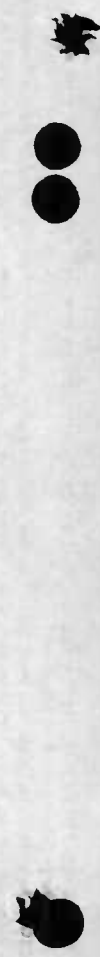
[Faint, illegible handwriting covering the main body of the page, possibly a letter or document.]

January, 18

February, 18

March, 18

April, 18



TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6983

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06969

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELLEN McDONALD				4. DATE OF DEATH Month Day Year JUNE 7 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/19/1882	
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ROBERT FREE				14. MOTHER'S MAIDEN NAME SUSAN BARNES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION of BRAIN (LEFT PARIETAL Lobe) DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOSIS BASILAR ARTERY DUE TO 8 days (c) GENERALIZED ARTERIOSCLEROSIS Yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/31 7:55 to 6/2 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at AM , from the causes and on the date stated above.							
22a. SIGNATURE S. H. L. LEON, M.D.				22b. DATE SIGNED 6/7/61			
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M.D.				22d. ADDRESS SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 10, 1961			
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City, town, or county) (State) Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter				25. REC'D BY REGISTRAR DATE JUN 9 '61			
25a. ADDRESS 254 Carroll St. NW. DC				25b. REGISTRAR'S SIGNATURE Carlton S. Hume			

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02889

CERTIFICATE OF DEATH

1887

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CERTIFICATE OF DEATH

Reg. Dist. No.

06970

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>4300-Baltimore Ave</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN lb <u>9 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 Baltimore Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>P.</u> Last <u>McKEON</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-78</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MICHAEL J. McKEON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET W. CRIPPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Henrietta Dumas #8 Upland Rd. Everet,</u>		Address <u>Mass.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>593 x</u> <u>Artemia -</u> <u>Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Arterio-Sclerotic Heart Disease -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18/56</u> , 19 <u> </u> , to <u>6/2/61</u> , 19 <u> </u> , that I last saw the deceased alive on <u>6/2/61</u> , 19 <u> </u> , and that death occurred at <u>855A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4501 - Conn. Ave. N.W. Wash. D.C.</u> DATE SIGNED <u>James C. O'Keefe</u>			
ACTUAL SIGNATURE <u>James C. O'Keefe</u>		M.D. <u>James C. O'Keefe MD</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Everett Malden, MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u>		ADDRESS <u>WASH. D. C.</u>	
FRANCIS J. COLLINS 3821 14th. St. N. W.		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6985

06971

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 113 Clyde Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Walter MEARS		4. DATE OF DEATH Month June Day 12 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-30
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 12 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Office Machines	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. MEARS		14. MOTHER'S MAIDEN NAME Mary E. CHANCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-26-4129	
17. INFORMANT (W) Mrs. Edoth C. Mears, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary insufficiency DUE TO (b) rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
INTERVAL BETWEEN ONSET AND DEATH 20 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 8 1961 to June 12 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 12 1961 and that death occurred at 6:25 AM from the causes and on the date stated above.			
22a. SIGNATURE B H Rice M.D.		22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15/61	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Cemetery		23d. LOCATION (City, town or county) (State) Wicomico Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co., 414 E. Church St., Salisbury, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06972

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 22 hours 15 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Atlantic City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 67 X-3 d. STREET ADDRESS 64 S. Carolina Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. Mehan		4. DATE OF DEATH June 17 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/86
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur finisher (retired) Furrier		11. BIRTHPLACE (County & State, or foreign country) Bird In Hand, Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John R. Frank- Wilson	
14. MOTHER'S MAIDEN NAME Unknown ? Knightie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. 150-09-3394		17. INFORMANT Mary Auel 41 Maytide St. Pittsburgh, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X cerebral vascular accident DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) 36 hours unknown years		INTERVAL BETWEEN ONSET AND DEATH 36 hours unknown years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 16 1961 to June 17 1961 , that (I) (we) last saw the deceased alive on June 17 1961 , and that death occurred at 6:08 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter, Jr. M.D.		22b. DATE SIGNED 6/17/61	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.		22d. ADDRESS 809 Veirs Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 21, 1961	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town or county) (State) Montgomery County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md. Raymond A. Ziska		25a. REC'D BY REGISTRAR JUN 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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(M)

(I)

James H. ...
Silver Spring, Md.
June 27, 1961
Dear Mr. ...

00033

CERTIFICATE OF DEATH

1983

(M)

DECEASED NAME: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CITY: [REDACTED]
STATE: [REDACTED]
ZIP: [REDACTED]

DECEASED NAME: [REDACTED]

DATE OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

CITY: [REDACTED]

STATE: [REDACTED]

ZIP: [REDACTED]

DECEASED NAME: [REDACTED]

DATE OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

CITY: [REDACTED]

STATE: [REDACTED]

ZIP: [REDACTED]

DECEASED NAME: [REDACTED]

DATE OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

CITY: [REDACTED]

STATE: [REDACTED]

ZIP: [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6988

06974

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>May 15, 1961</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5300 Westbard Avenue, Apt. 302 Westwood</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5300 Westbard Avenue, Apt. 302</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene Henry Messall</u>		4. DATE OF DEATH <u>June 8, 1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 16, 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Enid Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Mr. Homer Henry Louisiana, Missouri</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Russell Kansas</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. Victor R. Messall Apt. 302 Westwood Apts. 5300 Westbard Avenue Westwood, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> (c) <u>1 day</u> (e), stating the underlying cause last. <u>2 months</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1961</u> to <u>June 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 8, 1961</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John J. Curry</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>10620 Georgia Ave S.S. Ind</u>		22b. DATE SIGNED <u>6/8/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Montgomery County, Maryland</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u> <u>Raymond A. Zisk</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

00034

00034

(M)

1000 Westport Avenue, Apt. 302
New York, N.Y. 10011
April 15, 1961
Dear Mr. [Name]
I am writing to you regarding the [Subject]
[Name]
[Address]
[City, State, Zip]
[Phone Number]
[Signature]
[Name]
[Address]
[City, State, Zip]
[Phone Number]

(I)

1000 Westport Avenue, Apt. 302
New York, N.Y. 10011
April 15, 1961
Dear Mr. [Name]
I am writing to you regarding the [Subject]
[Name]
[Address]
[City, State, Zip]
[Phone Number]
[Signature]
[Name]
[Address]
[City, State, Zip]
[Phone Number]

6989

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06975

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Louise Last Meyer				4. DATE OF DEATH Month June Day 20 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1924	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 3 Days 2 Hours 3 Min.		IF UNDER 24 HRS. Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain (Nurse)				10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George J. Meyer				14. MOTHER'S MAIDEN NAME Anna Mayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Present				16. SOCIAL SECURITY NO. 308-22-5118		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Intestinal Obstruction DUE TO (c) Carcinoma of Rectum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 hrs. 2 weeks 3 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 24 19 61 to June 20 19 61 that (I) (we) last saw the deceased alive on June 20 19 61 , and that death occurred at 9:35 p.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>W. Walter Oppelt</i>				22b. DATE SIGNED 6/21/61			
22c. PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 24 JUNE 1961		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) HAUBSTADT INDIANA	
24. FUNERAL DIRECTOR'S SIGNATURE R. WALDI FUNERAL HOME INC., 816 H St. N.E. DC				25a. REC'D BY REGISTRAR JUN 23 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. The law also requires that the death certificate be retained by the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0087

CERTIFICATE OF DEATH

00872

M

The Clinical Center, Bethesda, Md., Md.
 308-22-5118
 Present
 Yes
 George J. Meyer
 Captain (Nurse)
 U.S. Air Force
 Indiana
 August 23, 1951
 36

The Medical Center, The National Center, Maryland
 308-22-5118
 Present
 Yes
 George J. Meyer
 Captain (Nurse)
 U.S. Air Force
 Indiana
 August 23, 1951
 36

I

The Medical Center, The National Center, Maryland
 308-22-5118
 Present
 Yes
 George J. Meyer
 Captain (Nurse)
 U.S. Air Force
 Indiana
 August 23, 1951
 36

The Medical Center, The National Center, Maryland
 308-22-5118
 Present
 Yes
 George J. Meyer
 Captain (Nurse)
 U.S. Air Force
 Indiana
 August 23, 1951
 36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED AND WILL APPROVE.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
06976															
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2224 Washington Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 330 West Side Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Irvin Middle RAY Last Middlekauff				4. DATE OF DEATH Month June Day 14 Year 19 61											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1883		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 6 Days 9		IF UNDER 24 HRS. Hours 26 Min. HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Auto Salesman				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Daniel J. Middlekauff						14. MOTHER'S MAIDEN NAME Amelia Margaret Downin									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-20-1458				17. INFORMANT Stella Middlekauff-wife-same 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROSIS GENERALIZED (c) DUE TO cause listed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 13 Jun. 1961 to 14 Jun. 1961 that (I) (we) last saw the deceased alive on 13 June 1961 , and that death occurred 1020 AM from the causes and on the date stated above.															
22a. SIGNATURE L. Marshall Cuvillier, Jr.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1407 Woodside Pkwy. Silver Spring				22b. DATE SIGNED 14 Jun. 61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/16/61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown, Maryland						25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

RECEIVED NOV 25 1965



11
Silver Spring
2224 Washington Avenue
Silver Spring
Nov. 25, 1965
Male
White
Height 5' 10"
Weight 175 lbs
Birth date 11-25-37
Birth place USA
Social Security 1-11-111111
Marital status Single
Occupation Engineer
Education B.S. in Mechanical Engineering
Employer Lockheed Martin
Address 2224 Washington Avenue, Silver Spring, MD 20910
Phone 443-2224
Religion Protestant
Hobbies Reading, Golfing
References: [illegible]
I, [illegible], certify that the above information is true and correct to the best of my knowledge and belief.
Signature: [illegible]
Date: Nov 25, 1965

08972

1001



TO HOSPITAL
death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6992

CERTIFICATE OF DEATH

06979

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7110 - 45th Street		d. STREET ADDRESS 7110 45th Street	
3. NAME OF DECEASED (Type or print) CLARA B. MORRIS		4. DATE OF DEATH June 7, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/4/69	
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tonica, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Boyley		14. MOTHER'S MAIDEN NAME Sarah J. Potter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Alta Marie Morris		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile dementia (c) Cerebral & generalized arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 mos. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe osteo arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug-Dec 1959 , to 7 June 1961 , that (I) (we) last saw the deceased alive on 6 June 1961 , and that death occurred at 12:35PM from the causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John G. Ball, M.D.		22d. ADDRESS 7936 Georgetown Rd., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 6/8/61	
23c. NAME OF CEMETERY OR CREMATORY 2901 14th St. N.W. Washington 9, D.C.		23d. LOCATION (City, town or county) (State) Tonica, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(I)

John H. Jones

Tonawanda, New York

2001 10th St. N.W.
Washington 25, D.C.

The S.E. Hines Co.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md. c. LENGTH OF STAY IN lb 5/21/61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 6348 - 31st Place N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) LILLIE First Middle Last				4. DATE OF DEATH 6 Month 21 Day 19 Year 61				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Carlisle, Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Hartman				14. MOTHER'S MAIDEN NAME Amelia Guise				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Elsie M. Bixler - Washington, D.C.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO (b) Arteriosclerosis - generalized Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.															
22a. SIGNATURE Harry N. Carlton				22b. DATE SIGNED 6/21/61				22c. PHYSICIAN'S NAME (Type) Harry N. Carlton				22d. ADDRESS 1522 Flora Ct. Sil. Sp. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/24/61				23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery				23d. LOCATION (City, town or county) (State) Carlisle, Penna.			
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company - Washington, D.C.				25a. REC'D BY REGISTRAR JUN 23 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

10000

10000

D.C.

Montgomery

(M)

Washington

1941/1

Washington, Md.

Washington Building Home

1941 - 1942 Place B.I.

SI

MOBILE

1941/1

1941/1

1941/1

U.S.

Caroline, Pa.

Honorable

American Union

William H. Brown

(I)

1941-1942 B.I.

1941-1942 B.I. - Washington, D.C.

name

no

Handwritten signature

1941/1

Handwritten signature

1941-1942 B.I. - Pa.

Henry H. Carlson

Caroline, Pa.

Washington Building Home

1941/1

The H. H. Hines Company - Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6994

06981

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 25 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle M. Last NEWMAN				4. DATE OF DEATH Month JUNE Day 12 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-22-1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM E. SMITH				14. MOTHER'S MAIDEN NAME LAURA O. Ogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, Laennec's type 581.1 DUE TO OF Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Bronchopneumonia, Bilateral							INTERVAL BETWEEN ONSET AND DEATH One Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) S					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-18-1961 to 6-12-1961 , that (I) (we) last saw the deceased alive on 6-11-1961 , and that death occurred at 2:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Little Vine		23d. LOCATION (City, town, or county) (State) Sylvatus, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John L. N. Polesworth				ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2

1

M

I

1893

CERTIFICATE OF DEATH

1893

DECEASED

IN DAYS

YEAR

1893

DECEASED BY NAME AND RESIDENCE

AGE

SEX

CAUSE

DECEASED

DATE OF DEATH

PLACE OF DEATH

HOSPITAL BUILDING, NEW YORK

ORDER OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6995

06982

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>	
c. LENGTH OF STAY IN 1b <u>14 days</u>		d. STREET ADDRESS <u>139 Ritchie Ave</u>	
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>JAMES</u> Middle <u>Nicholson</u> Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/19</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Amer.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>JAMES MOORE</u>		14. MOTHER'S MAIDEN NAME <u>Clemmie Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pt Charx</u>	
17. INFORMANT <u>Pt Charx</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC TAMPONADE</u> <u>022X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>RUPTURED AORTIC ANEURYSM</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 21</u> , 19 <u>61</u> , to <u>JUNE 4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>JUNE 3</u> , 19 <u>61</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.		22b. DATE SIGNED <u>6-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR.</u>		22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ship To -</u>		23d. LOCATION (City, town or county) (State) <u>Scotland Neck, North Carolina</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Risher</u> ADDRESS <u>1432 You St., N.W.</u>		25a. REC'D BY REGISTRAR <u>JUN 15 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

VR A15 (4)
15M 9/60

00283

M

1

Spokane, Wash. 10/10/1918

Dear Sir:

Enclosed

is

Very truly yours,
J. H. Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6996		Item 9 Film G288		06983	
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 2 mo</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Portia Meredith Oberly</u>		4. DATE OF DEATH <u>June 5 1961</u>		9. AGE (In years last birthday) <u>86 7/11</u> yrs.	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4 1874</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>John H. Oberly</u>		14. MOTHER'S MAIDEN NAME <u>Helen Sackewers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Virginia Malone</u> Address <u>Moriches Rd. St. James L.I. N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephritis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, Residual polio myelitis</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10/25 5:55 AM</u> to <u>6/5 61</u> , that (I) (we) last saw the deceased alive on <u>5/28 1961</u> , and that death occurred on <u>6/5 1961</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Wigton</u>		22b. DATE SIGNED <u>6/5/61</u>		22c. PHYSICIAN'S NAME (Type) <u>C. H. Wigton</u>	
22d. ADDRESS <u>Sandy Spring, Md.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley Sons</u> ADDRESS <u>1756 Pa Ave. Wash. D.C.</u>			
25a. REC'D BY REGISTRAR <u>DATE JUN 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1900

1900

(M)

Name of Deceased		Date of Birth	
John Doe		Jan 1, 1850	
Place of Birth		Date of Death	
New York City		Jan 1, 1900	
Cause of Death		Place of Death	
Heart Disease		New York City	
Occupation		Signature of Registrar	
Teacher		[Signature]	
Manner of Death		Date of Entry	
Natural		Jan 1, 1900	
Buried at		Signed	
St. John's Church		[Signature]	
Buried by		Date of Burial	
John Doe		Jan 1, 1900	
Witnessed by		Date of Witnessing	
John Doe		Jan 1, 1900	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06985

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 224 "A" Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 324 Cedar Lane							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
Edna		Gertrude		Pace			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1893	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Forrest				14. MOTHER'S MAIDEN NAME Sarah Koontz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Lois Nuse, Rockville, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Endometrium 172X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Esophageal Hiatal Hernia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/24/61 to 6/10/61 , that (I) was last saw the deceased alive on 6/7/61 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Arthur F. Woodward		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/10/61	
22c. PHYSICIAN'S NAME (Type) Arthur F. Woodward		22d. ADDRESS Rockville - Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-1961		23c. NAME OF CEMETERY OR CREMATORY Park Heights		23d. LOCATION (City, town or county) (State) Brunswick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. W. Fuld		ADDRESS Brunswick, Maryland		25a. REC'D BY REGISTRAR DATE JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VR A15 (4)
15M 9/60

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Expenditure of the State

John J. Buchanan

4/10/61
6/10/61
X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4617-42nd. St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose M. Parenteau</u>				4. DATE OF DEATH Month Day Year <u>June 9 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/13/98</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Minn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Jefferson Porter</u>				14. MOTHER'S MAIDEN NAME <u>Philomene Emard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-42-1257</u>			
17. INFORMANT <u>Edward W. Parenteau</u> Address <u>4617-42nd St NW Wash DC</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Myocardial Infarction</u>							
(c) <u>Coronary Occlusion</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 8 1961</u> to <u>June 9 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>June 9 1961</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Elaine W. Murphy M.D.</u>				22b. DATE SIGNED <u>6-10-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. Murphy</u>				22d. ADDRESS <u>4812 Ellicott St NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town, or county) (State) <u>Ga. Ave. Silver Spring Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home Inc D.C.</u> ADDRESS <u>3003 3rd St. N.W.</u>				25a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death.

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CERTIFICATE OF DEATH

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Chief of Police
City of New York

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7000

06987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. Va.</u> b. COUNTY <u>Clarksburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C. P5X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>4323 PARRILL COURT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorsey</u> Middle <u>H.</u> Last <u>PARRILL</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-75</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — — —</u>		11. BIRTHPLACE (State or foreign country) <u>West. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph P. Parrill</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Foley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>— — — —</u>		17. INFORMANT <u>D.H. PARRILL, 2139-WISC. AVE. N.W.</u> Address <u>WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consolidation - fld. rlung - (poss. malign.)</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic ht. disease - chronic</u> DUE TO <u>2 yrs.?</u> (c) <u>Urinary infection assoc. w/ prostatic</u> DUE TO <u>5 mos.?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.?</u> <u>5 mos.?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> <u>1961</u> to <u>6/23</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> <u>1961</u> , and that death occurred at <u>3:34</u> <u>AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u>				22b. ADDRESS <u>8218 WISCONSIN AV. BETH.</u>		22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>6-23-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BRIDGEPORT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARKSBURG, W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph E. Quinn, Jr., Inc. 1756 Pa. Ave. N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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1923

DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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(M)



(1)



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7001

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06988

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9804 E. Bexhill Drive				d. STREET ADDRESS 9804 E. Bexhill Drive			
3. NAME OF DECEASED (Type or print) First NELL Middle CATHERINE Last PAXTON				4. DATE OF DEATH Month JUNE Day 7 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1893	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 7 Days 15		IF UNDER 24 HRS. Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (County & State, or foreign country) Indiana				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis Harrell				14. MOTHER'S MAIDEN NAME Alma Burt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Kent Paxton-Husband-Same Item #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF BASILAR ARTERY 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) CEREBRAL ARTERIOSCLEROSIS (c) 1 YEAR DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 HOURS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 10, 1948 to JUNE 7, 1961 , that (I) (we) last saw the deceased alive on JUNE 7, 1961 , and that death occurred at 10:30 P. from the causes and on the date stated above.							
22a. SIGNATURE Thomas S. Sappington				22b. DATE SIGNED JUNE 7, 1961		22c. PHYSICIAN'S NAME (Type) Thomas S. Sappington, M.D.	
22d. ADDRESS 1025 CONNECTICUT AVE., NW.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 6/8/1961		23c. NAME OF CEMETERY OR CREMATORY West Point Cemetery		23d. LOCATION (City, town or county) (State) Liberty Indiana	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

Kennington
1804 E. Rexhill Drive

Kennington
3304 E. Rexhill Drive

(NELL)

CATHERINE PAXTON

Oct. 23, 1893

Oct. 23, 1893

Houswife

Indiana

Louis Hartsell

Alma Burr

(I)

No

Unknown

Ken Paxton-Husband-Same Item 13

1804 E. Rexhill Drive

West Point Cemetery

Liberty

Indiana

Robert A. Humphrey

Bethesda, Maryland

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 11½ yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			d. STREET ADDRESS 516 Marietta St.	
3. NAME OF DECEASED (Type or print) First Cora Middle Lee Last Payne		4. DATE OF DEATH Month June Day 27 Year 1961		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 27, 1878		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Perry Weimer	
13. FATHER'S NAME Perry Weimer		14. MOTHER'S MAIDEN NAME Catherine Zebauch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown INTERVAL BETWEEN ONSET AND DEATH 5 minutes									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 2-2 19 61 , to 6-27 19 61 , that (I) (we) last saw the deceased alive on 6-22 19 61 , and that death occurred at 2:30 PM, from the causes and on the date stated above.	
22a. SIGNATURE James W. Egan		22b. PHYSICIAN'S NAME (Type) James W. Egan		22c. PHYSICIAN'S ADDRESS 7720 Wisconsin Ave., Bethesda 14, Md.		22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 3 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24. ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		25c. DATE JUL 3 '61		25d. REGISTRAR'S SIGNATURE	

M

I

1908

CERTIFICATE OF DEATH

07883

MA

Residence

Residence

Place of Birth

Place of Birth

Age at Death

Age at Death

Color

Color

Sex

Married

Married

Cause of Death

Cause of Death

Occupation

Occupation

Signature

Signature

1908

1908

James W. Smith

James W. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7003

CERTIFICATE OF DEATH

Reg. Dist. No. 06990

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 43 Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4410 Puller Drive				e. STREET ADDRESS 4410 Puller Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adelaide Stagemann PECA				4. DATE OF DEATH Month June Day 2 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1873		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 9 Days 1	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA-Naturalized
13. FATHER'S NAME John Stagemann				14. MOTHER'S MAIDEN NAME Dorthea VonWerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dorothea Armstrong-Daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure							6 hrs.
2867 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Hypoproteinemix, Anemia							6-8 mo.
DUE TO							
(c) Chronic Dehydration							2-3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Rheumatoid Arthritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1959 , to June 2, 1961 , that I last saw the deceased alive on June 1, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.				ADDRESS (Street, city or town, state) 10609 Concord Street			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.				Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 8 '61	
				24b. REGISTRAR'S SIGNATURE William S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7004

06991

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 56 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Williamsburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg d. STREET ADDRESS 5 Bayberry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Green PEYTON		4. DATE OF DEATH Month June Day 28 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-94
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard PEYTON		14. MOTHER'S MAIDEN NAME Louise RAMSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1911 - 1947	
17. INFORMANT (W) Mrs. Mary M. Peyton, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, with metastases DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200-1			
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from May 3 11:45 PM to June 28 1961 , that 10 (we) last saw the deceased alive on June 28 1961 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE B. L. KELLEY, LT, MC, USN		22b. DATE SIGNED 6-29-61	
22c. PHYSICIAN'S NAME (Type) B. L. KELLEY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-3-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR JUL 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		25c. DATE JUL 3 '61	

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



0004

0001

Belmont (Hurt)

U. S. Naval Hospital

Thomas

Constitution

U. S. Navy

Norman Horton

1911 - 1914

Yes

Vip. In

Positive Answer

(W) Mrs. Mary H. Horton, same as above

Investigation, with no change

Jan 20

D. J. KATZ, 1st WO, USN

7-1-01

H. K. Pumphrey, Hospital Home, Bethesda, Md.

Washington National

Clinton

Virginia

U. S. Naval Hospital, Bethesda, Md.

7005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06992

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>14124 - Aspen St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd J. Porter</u>				4. DATE OF DEATH Month Day Year <u>June 2 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/4/183</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Patent Office N.Y.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John B. Porter</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Dana</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Blanche H. Porter</u>		Address <u>1504 H. Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Fracture of Neck of Right Femur</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home - incurred due to Gen. Arteriosclerosis</u>			
20c. TIME OF INJURY Month, Day, Year <u>May 21 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Cherry Chase Md.</u> (County) <u></u> (State) <u></u>			
21. I certify that (1) (this hospital) attended the deceased from <u>June 1</u> 19 <u>53</u> , to <u>June 2</u> 19 <u>61</u> , that (2) (we) lost saw the deceased alive on <u>June 1</u> 19 <u>61</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John R. Ewan</u>				22b. DATE SIGNED <u>6/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>John R. Ewan - MD</u>				22d. ADDRESS <u>1835 Eupst. N.W. Washington - DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u>Prince Geo. Co. Maryland</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u> DATE <u>JUN 8 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

Coroner notified and will Approve.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G288 6/14/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

06993

7005

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SANDY SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 SANDY SPRING</u>			
c. LENGTH OF STAY IN 1b <u>65 yrs</u>				d. STREET ADDRESS <u>1 SANDY SPRING RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
		<u>MARY Alice POWELL</u>		<u>JUNE</u>		<u>3 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1896</u>	9. AGE (In years last birthday) <u>64 6/8</u> yrs.	IF UNDER 1 YEAR: Months Days Hours		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, MONTGOMERY CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD HILL</u>				14. MOTHER'S MAIDEN NAME <u>SARAH JANE POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>SARAH FRANCES POWELL</u>		Address <u>SANDY SPRING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>53</u> to <u>JUNE</u> , 19 <u>61</u> ; that I last saw the deceased alive on <u>MAY 31</u> , 19 <u>61</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>SILVIAN K. ZIEGLER</u> M.D. <u>OLNEY, MD.</u> <u>JUNE 3, 1961</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASH MEMORIAL.</u>		22d. LOCATION (City, town, or county) (State) <u>SANDY SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT L. SNOWDE</u> ADDRESS <u>ROCKVILLE, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>ARTHUR S. FRANKS</u>	

Page 4

hours after death

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 72 hours after death.

VS A15 (4) 15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08933

DEATH

2007

(M)

8

(I)

John Spring, Jr.

John Spring, Jr.

5/5/57

Spring

John Spring, Jr.

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7007											
06994											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 98 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 14241 Layhill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Paul First Robert Middle PREPELICA Last			4. DATE OF DEATH June Month 10 Day 1961 Year								
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1 1961		9. AGE (In years last birthday) 0 yrs. 18 Months 19 Days		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Montgomery Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William John PREPELICA					14. MOTHER'S MAIDEN NAME Delores Maxine COLBERT						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT William J. PREPELICA (Father) Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 DAYS										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1961 to June 10, 1961		(County) Montgomery		(State) Md.
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1 1961 to June 10 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 10 1961 , and that death occurred at 1215AM , from the causes and on the date stated above.											
22a. SIGNATURE Robert V. Rack M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 6-10-61			
22c. PHYSICIAN'S NAME (Type) Robert V. RACK LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-14-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia			23d. LOCATION (City, town or county) (State) Rockville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Tyson Wheeler Funeral Home, 1331 Montgomery Ave.					25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans				

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Robertson (Brent)

U. S. Naval Hospital

San

Info - Unavailable

CHIEF

William John Robertson

(William J. Robertson) (Robert)

Robert J. Robertson

Robert J. Robertson, USN

U. S. Naval Hospital, San

1-11-11

Robert J. Robertson, USN

Robert J. Robertson, USN

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the law requires that the death certificate be executed within 72 hours after death.

7008

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06995

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 64 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2355 East 27th Street			
3. NAME OF DECEASED (Type or print) First Stanley Middle (None) Last Press				4. DATE OF DEATH Month June Day 15 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1934	
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Provision		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Philip Press				14. MOTHER'S MAIDEN NAME Bertha Fayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1957-1959		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO (c) 48 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 12 19 61 to June 15 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 15 19 61 , and that death occurred at 8:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE- Richard E. Rieselbach				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/16/61	
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-18-61		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) NEW YORK, N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS 3501 14th Street, N.W.				25. REC'D BY REGISTRAR JUN 19 61		25b. REGISTRAR'S SIGNATURE Charles S. F...	

MEDICAL CERTIFICATION

100000

New York

Brooklyn

235 East 37th Street

Irish

March 23, 1934

New York

London, England

The Medical Society

The Clinical Center, Belmont, N.Y.

London, England

London, England

April 12

June 12

MICHAEL E. MURPHY, M.D.

1910-1911

CLINICAL MEDICINE & SURGERY, N.Y.

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7009

06996

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown (Rural) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marylander Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9628 Acord Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Elizabeth Ragan		4. DATE OF DEATH Month June Day 18 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months 6 Days 11 IF UNDER 24 HRS. Hours --- Min. ---
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis McCarthy		14. MOTHER'S MAIDEN NAME Mary O'Brien	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph B. Ragan-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia, Bifactoral 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Edema, Congestive Hrt. Failure (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic Hypertensive Heart Disease INTERVAL BETWEEN ONSET AND DEATH 6 days 11 days 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 6 June 1961 (County) Washington, D. C. (State)
21. I certify that (I) (this hospital) attended the deceased from 6 June 1961 to 18 June 1961 , that (I) (we) last saw the deceased alive on 17 June 1961 , and that death occurred at 9:01 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon M. Smith		22b. DATE SIGNED 6/18/61	
22c. PHYSICIAN'S NAME (Type) Gordon M. Smith		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Dawsonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/21/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) Washington, D. C. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE JUN 21 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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Thompson

Maryland

Thompson

Bedford

Bedford (Hwy)

9000 North Drive

9000 North Drive

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Washington, D. C.

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Washington, D. C.

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Joseph B. Thompson

None

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6 days

Robert Thompson, Dated

Palmer's Electric, Capitalist, Failure 11 days

Arterio 2 locate Hypertensive Hunt B 2 years

Left Hand plegia

June 10

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Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Robert A. Thompson, Bethesda, Maryland

Robert A. Thompson, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7010

06997

1. PLACE OF DEATH a. COUNTY Montgomery M b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 1 mo. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3000 Mc Comas Ave. Kensington Gardens				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 10608 Nash Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK V. RAND			4. DATE OF DEATH Month June Day 6 Year 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mch. 16, 1883	9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 2 Days 20	IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Bact. & Path.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt-Agric.		11. BIRTHPLACE (County & State, or foreign country) Vermont			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Rev. Wilbur Rand				
14. MOTHER'S MAIDEN NAME Mary Jane Miller			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 263-46-4843A			17. INFORMANT Louva H. Rand-wife-Same as Item #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia - 332X DUE TO (b) Cerebral Thrombosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebral Arteriosclerosis -					INTERVAL BETWEEN ONSET OF DEATH 2 days 21 days 7 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from May 1, 1961 to June 6, 1961 , that (I) was last saw the deceased alive on June 6, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Neil P. Campbell		22b. DATE SIGNED 6-6-61	22c. PHYSICIAN'S NAME (Type) NEIL P. CAMPBELL				
22d. ADDRESS 3060 - 16th St., N. W., Washington		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 6/7/61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) Prince Georges Maryland				
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 8 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2010

1997



Montgomery

Maryland

Montgomery

Kenneth

1 mo. 5 days

Kenneth

Kenneth's Garden
3000 No. 1st Ave.

19008 Nash Place

FRUIT

FRUIT

FRUIT

White

Mon. 15, 1883

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Plant Root & Path.

U. S. Govt. Agric.

Vermont

USA

Rev. William Hand

Mary Jane Miller

No

323-44-1843A Louis H. Hand-wife-same as item 12

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Handwritten signature or text

WILL T. CAMPBELL

2050 - 15th St., N. W., Washington

Cremation

6/7/81

Cedar Hill Crematory

Prince Georges Maryland

Robert A. Humphrey Bethesda, Maryland

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/59

Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7011

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7011

CERTIFICATE OF DEATH

06998

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u>		c. LENGTH OF STAY IN lb <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BLANCHE HANNAH RANDALL</u>		4. DATE OF DEATH Month Day Year <u>6 15 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/81</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min. <u>+</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BEN PHILIPS</u>		14. MOTHER'S MAIDEN NAME <u>GRAHAM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Margie Marie Randall</u>		Address <u>110 St. Lawrence Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>CARCINOMA OF COLON</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 MONTHS</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>June 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1961</u> , and that death occurred at <u>11:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Irey</u>		22b. DATE SIGNED <u>6-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Raymond A. Wiskar</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25c. DATE <u>JUN 20 '61</u>	

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CERTIFICATE OF DEATH

1911

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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VS. A1SME
SM 9/60

7812
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7812
MAYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
06999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>1800 Hollywood Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>800 Hollywood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Donald Rankin</u>		4. DATE OF DEATH <u>June 22 1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-1903</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Clerk (Mail) DC Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>R. I.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Bright Rankin</u>	
14. MOTHER'S MARRIED NAME <u>Mary Erskins</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>117-07-1502</u>		17. INFORMANT <u>Clara Rankin (wif.)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 24, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MAYFLOWER HILL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>TAUNTON, MASSACHUSETTS</u>	
23. FUNERAL DIRECTOR <u>WAGNER E. PUMPHREY, INC. SILVER SPRING, MD.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>6-22-61</u>	

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Page 4
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7013
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9415 11 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				d. STREET ADDRESS <u>4930 Butterworth Pl. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Rheinbold</u> Last <u>Rheinbold</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1869</u>	
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Deinger</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Frederick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Washington DC</u> <u>Mrs. Lydia Mosley 2240 Hall Pl. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>15 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 17, 1961</u> to <u>June 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Havell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell, MD.</u>				22d. ADDRESS <u>5516 Neb. Ave. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.A. Hine Co. 2901-12 St. A.W. DC</u>				ADDRESS <u>Washington DC</u>		25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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CENTRAL B. OF DEATH

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TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
7014										
CERTIFICATE OF DEATH										
07001										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 3904 Cavendish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Oscar RISINGER					4. DATE OF DEATH Month June Day 14 Year 1961					
5. SEX Male					6. COLOR OR RACE Caucasian					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 5-27-26					
9. AGE (In years last birthday) 35 yrs.					10. IF UNDER 1 YEAR Months 7 Days 14 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer					10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps					
11. BIRTHPLACE (County & State, or foreign country) Texas					12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William O. RISINGER					14. MOTHER'S MAIDEN NAME Mary Eula NICHOLS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1942-1961 463-26-0848					
17. INFORMANT (W) Mrs. Ann C. Risinger, same as #2 above					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma of Rectosigmoid with metastasis 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 7 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that he (this hospital) attended the deceased from May 16, 1961 to June 14, 1961 , that he (we) last saw the deceased alive on June 14, 1961 , and that death occurred at 6P.M. from the causes and on the date stated above.										
22a. SIGNATURE Larry J. Hines M.D.					22b. DATE SIGNED 6-15-61					
22c. PHYSICIAN'S NAME (Type) Larry J. HINES, CDR, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 6-20-61					
23c. NAME OF CEMETERY OR CREMATORY Arlington National					23d. LOCATION (City, town or county) (State) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. W.W. Chambers Co., 1400 Chapin St., NW, WashDC					25a. REC'D BY REGISTRAR DATE JUN 19 61					
25b. REGISTRAR'S SIGNATURE Arthur S. Hines										

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Virginia

Virginia

Richmond (Harris)

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Richmond

U. S. Naval Hospital

3000 Cavendish Drive

Robert

Richmond

June

June

Richmond

Richmond

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Richmond

U. S. Marine Corps

Texas

William C. RICHMOND

Mary ELA RICHMOND

Richmond

Richmond

Richmond, name as above

June 14 1961

U. S. Naval Hospital, Richmond, VA

Richmond

W. Chambers Co., 1400 Chapin St., N.W., Washington

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7015

07002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>31 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u> d. STREET ADDRESS <u>213 Ritchie Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oswald J. Roccati</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Turin, Italy</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-1976</u>		17. INFORMANT <u>Arnold Roccati (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Prostate carcinoma, congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>1 June</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>31 May</u> , 19 <u>61</u> , and that death occurred at <u>1:40</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>John G. Ball</u>				22b. DATE SIGNED <u>2 June 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				22d. ADDRESS <u>7936 Old Georgetown Rd., Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				25a. REC'D. BY REGISTRAR <u>June 5 1961</u>			
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Howard</u>				25c. ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>			

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John M. Black

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John M. Black

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FOR STATE
HEALTH DEPT.

7016
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07003

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11305 Clover Hill Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman First N.M.N. Middle Rosner Last		4. DATE OF DEATH June Month 11 Day 1961 Year			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 24, 1914		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Morris Rosner (DEC)		14. MOTHER'S MAIDEN NAME Sarah KLEIN (DEC)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 055-10-7740		17. INFORMANT Washington Sanitarium and Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem compression 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral laceration + hemorrhage DUE TO (c) Bullet wound thru rt temple INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted bullet wound thru rt temple			
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 6-9 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Silver Spring Monty md		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschert		M.D.		DATE SIGNED 6-11-61	
EXAMINER'S NAME (Type) FRANK J. BROSCHE		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/14/61		22c. NAME OF CEMETERY OR CREMATORY ARL. NAT'L. Cem.	
22d. LOCATION (City, town, or country) ARL. VA.		22e. (State)			
23. FUNERAL DIRECTOR Goldberg & Sons		ADDRESS 4217 Ebb St NW		24a. REC'D BY REGISTRAR JUN 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

Montgomery

Takeover for

2 days

silver spread

Washington State University Hospital 11002 Clover Hill Drive

1000 B. Ave. June 1961

Male white

August 24, 1961

Salesman New Estate New York

I Morris Rosner

for my family Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

X

Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

Washington State University Hospital

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07004

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1550 East West Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) John Gray ROWE		4. DATE OF DEATH Month June Day 29 Year 61		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-07		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (County & State, or foreign country) California				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Phillip H. ROWE				14. MOTHER'S MAIDEN NAME Frances J. SIMMONS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1927 to 1957 224-52-8212				17. INFORMANT (Wife) Mrs. Anna Mae Rowe, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hours												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 29, 1961 to June 29, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 29, 1961 , and that death occurred at 5:02 PM , from the causes and on the date stated above.																			
22a. SIGNATURE Russell Miller, Jr. M.D.				22b. DATE SIGNED 6-30-61				22c. PHYSICIAN'S NAME (Type) Russell MILLER, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-3-61				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE S.H.Hines Funeral Home, 2901 14th St., NW, WashDC				25a. REC'D BY REGISTRAR DATE JUL 3 '61				25b. REGISTRAR'S SIGNATURE Carleton L. Kraus											

07004

0017

(M)

(1)

Montgomery Maryland

Montgomery

Stivers Spring

Stivers

Bedford (Rural)

1250 East West Highway

U. S. Naval Hospital

June 29 1941

Gray John

11-21-07

U. S. Naval Hospital

USA

U. S. Navy

Office

Francis J. Sullivan

Philip H. Kohn

1001 1st St. S.W. (Rm. 101) Wash. D.C. 20304

June 29 1941

June 29 1941

0-30-01

Russell Miller, Jr., LT, USN, U. S. Naval Hospital, Bethesda, Md.

Atkinson National Arlington Virginia

U. S. Naval Hospital, 2001 First St., Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G288 6/12/61 iwl

07005

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE New York		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 86 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ozone Park, Long Island		69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 10717-88th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia		Middle Rose		Last Ruggieri		4. DATE OF DEATH Month June	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1900	
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months 61		11. IF UNDER 24 HRS. Days 60		12. IF UNDER 24 HRS. Hours 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carmelo Marotta				14. MOTHER'S MAIDEN NAME Angelina Ruggieri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycosis Fungoides; with Congestive Heart Failure 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1961 to June 1, 1961 that (I) (we) last saw the deceased alive on June 1, 1961 and that death occurred at 2:58 p.m. from the causes and on the date stated above.							
22a. SIGNATURE R. B. Scoggins				22b. DATE SIGNED 6/2/61		22c. PHYSICIAN'S NAME (Type) R. B. SCOGGINS, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				22e. REC'D BY REGISTRAR DATE JUN 8 '61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-61		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) Long Island, New York	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REGISTRAR'S SIGNATURE Bethesda, Md.		25b. REGISTRAR'S SIGNATURE William S. Frawley	

17002

EXHIBIT OF CASE

0018

Montgomery
Beach
60 days
Ochoe Pass, Long Island

The Clinical Center
1011-10th Street
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

Female
Wills
New York

7019

1. PLACCE OF BIRTH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9701 Stoneham Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Therese Schanzer		4. DATE OF DEATH June 9 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-14-1899	
9. AGE (In years last birth) 61 yrs.		IF UNDER 1 YEAR 11 Months 25 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Hat Designer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Naturalized	
13. FATHER'S NAME Landau		14. MOTHER'S MAIDEN NAME Beatrice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153.9 Cancer, intestinal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) histologic diagnosis unknown to me (c) Emmanuel Stein MD, 225 West 86th St, NYC, had been physician until 5/29/61.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 29 1961 to June 5 1961 , that (I) (we) last saw the deceased alive on 6/5 1961 , and that death occurred at 11:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Allen J. O'Neil MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Allen J. O'Neil MD		22d. ADDRESS 8601 Old Georgetown Rd, Bethesda	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/12/1961	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE James S. Thomas		DATE JUN 12 '61	

VR A1S (4)
ISM 9/59

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7020
CERTIFICATE OF DEATH
07007

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1715 Kilbourne St., N. W. d. STREET ADDRESS 1715 Kilbourne St., N. W. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Charles Henry SCHMACKEL				4. DATE OF DEATH Month June Day 6 Year 19 61															
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 12-18-92		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces				10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps				11. BIRTHPLACE (County & State, or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME (unknown) SCHMACKEL				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & II							
17. INFORMANT (D) Mrs. Clara E. Robertson,				Address Kansas City, Mo.				3842 Wyandotte St.,				INTERVAL BETWEEN ONSET AND DEATH 2 wks							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO (b) Cirrhosis, Laennec's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 26 19 61 to June 6 19 61		(County) 10:20PM		(State) 10:20PM							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 26 19 61 to June 6 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6 19 61 , and that death occurred at 10:20PM , from the causes and on the date stated above.																			
22a. SIGNATURE R. G. Muth				M.D. R. G. MUTH, LT, MC, USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> W. S. Naval Hospital, Bethesda, Md.				22b. DATE SIGNED 6-7-61							
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d. ADDRESS W. S. Naval Hospital, Bethesda, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-9-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.,				ADDRESS 3072 M St., NW, Washington, DC				25a. REC'D BY REGISTRAR DATE JUN 9 '61				25b. REGISTRAR'S SIGNATURE Charles S. Thomas							

10070

10070

Director of Columbia

Director of Columbia

Washington

11 days

Secretary (Mr. L.)

1725 Killebrew St., N. W.

U. S. Naval Hospital

HONOLULU

Henry

Charles

June

12-12-52

Chas. L.

Mr.

USA

Illinois

U. S. Marine Corps

1st Lt.

Unknown

(unknown) JOHN CHAS.

1st Lt. Chas. H. Robertson, 1st W. N. Co.,
Kansas City, Mo.

W. I. & L.

June 6

May 25

June 6

X

6-7-51

U. S. Naval Hospital, Bethesda, Md.

E. G. HUNT, LT, USN

Virginia

Arlington

Arlington National

6-9-51

Bureau

W. M. Chambers Co., 101 W. 11th St., Washington, D. C.

Page 4
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death.
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7021
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07008

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83x-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Route #5, Box 432	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle ANN Last SCHMITT		4. DATE OF DEATH Month June Day 19, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1925
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dawson		14. MOTHER'S MAIDEN NAME Victoria Cawman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uterine Tumor, indifferntiated, Metastatic to lungs, mouth, brain DUE TO 235x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from May 29, 1961 to June 19, 1961 , that (I) (we) last saw the deceased alive on June 19, 1961 , and that death occurred at 8:30 a.m. from the causes and on the date stated above.	
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22a. SIGNATURE Haskins K. Kashima M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/19/61	
22c. PHYSICIAN'S NAME (Type) HASKINS K. KASHIMA, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 June 61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
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24. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home Inc. ADDRESS Box 65, Alex., Va.		25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7022

07003

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney Rural</u>		c. LENGTH OF STAY IN 1b <u>3 yr 10 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		83 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>4731 N 34th St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Mayer</u> Last <u>Schuler</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 2 1871</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pao</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>John Mayer</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Landis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mr Cook 4731 N 34th St Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>occlusion of left internal carotid artery</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>61</u> to <u>6/5</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>6/5</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>John P. Martin</u>				22b. DATE SIGNED <u>6/5</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN MARTIN</u>				22d. ADDRESS <u>OLNEY MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>June 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Charles Evans</u>		23d. LOCATION (City, town, or county) (State) <u>Reading Penn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber Laytonville Ind.</u>				25a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07008

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07010**

7023

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY Rensselaer			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Acres			c. LENGTH OF STAY IN 1b 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Schenectady 69X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5319 Wakefield Road				d. STREET ADDRESS 36 Swan Street Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle H. Last SCOTT				4. DATE OF DEATH Month June Day 15 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 9 Days 16	IF UNDER 24 HRS. Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Nowell Scott				14. MOTHER'S MAIDEN NAME Clara Hynds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Yes Unknown		17. INFORMANT Leo Scott-Son-same as 1d			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (c), stating the underlying cause last, DUE TO							INTERVAL BETWEEN ONSET AND DEATH Sudden years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetic mellitus 6 years				
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify),		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur-Transit		6/20/61		Bramanville Cemetery		Bramanville, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 19 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7024

Item 9 Film G288 6/9/61 mh

07011

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		d. STREET ADDRESS Brown Street	
3. NAME OF DECEASED (Type or print) First Sarah Middle Wall Last Seaton		4. DATE OF DEATH Month 6 Day 4 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1880
9. AGE (In years last birthday) 81 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY " "	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Andrew Wall		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 29 1961 to June 5, 1961 , that (I) (we) last saw the deceased alive on June 5, 1961 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Luciano L. Leal M.D.		22b. DATE SIGNED June 4, 1961	
22c. PHYSICIAN'S NAME (Type) Luciano L. Leal		22d. ADDRESS Gaithersburg Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 6-7-61	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City, town, or county) (State) Mladensburg Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		25a. REC'D BY REGISTRAR Gaithersburg Md. 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

05012

UNITED STATES OF AMERICA

102

(M)

THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JANUARY 1, 1902

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [illegible]

RE: [illegible]
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

(I)

CHIEF OF BUREAU

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

AP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
7025											
07012											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 47 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 12101 Porttree Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Petrina August^a						4. DATE OF DEATH Month June Day 16 Year 19 61					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-04		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hallgrimur GOTTSKALKSON						14. MOTHER'S MAIDEN NAME Ingbjorg FOSS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address (S) Lt. K. W. Sell, MC, USN, same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 170X Carcinoma Breast - Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1961 to June 16, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 16, 1961 , and that death occurred at 10:07 AM , from the causes and on the date stated above.											
22a. SIGNATURE W. D. Hooper M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-16-61			
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-61		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) Rockville		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Tyson Wheeler Funeral Home, Rockville, Md.						25a. REC'D BY REGISTRAR DATE JUN 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

2

1096

MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7026

07013

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 5917 - LeMay Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hilda Middle L. Last Shafer				4. DATE OF DEATH Month 6 Day 14 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/30/21		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Taunton, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Jones				14. MOTHER'S MAIDEN NAME Hilda Hathaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 415-18-0054		17. INFORMANT Miss Janice Jones 1310 Chillum Rd. Apt. 104			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, breast = Metastases DUE TO lying cause last. (c) 18m							INTERVAL BETWEEN ONSET AND DEATH 3 w
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/31 19 61 , to 6/14 19 61 , that (I) (we) last saw the deceased alive on 6/14 19 61 , and that death occurred at 3:25 P. from the causes and on the date stated above.							
22a. SIGNATURE J. H. Tuohy				22b. DATE SIGNED 6/15/61		22c. PHYSICIAN'S NAME (Type) J. H. TUOHY, M.D.	
22d. ADDRESS 7720 WISCONSIN AVE BETHESDA 14, MD.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

074

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EP

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07014

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY in 1b <u>DOA.</u>				d. STREET ADDRESS <u>8123-14th Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Jeffer</u> Last <u>Shantz</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>			
13. FATHER'S NAME <u>PHILLIP</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>MR. IRVING SHANTZ - SON</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Booschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BOOSCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-16-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>6/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		22d. LOCATION (City, town, or county) (State) <u>MASPETH, N.J.</u>	
23. FUNERAL DIRECTOR <u>Goodberg Funeral Home</u>				24a. REC'D BY REGISTRAR <u>4217</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			
				DATE <u>JUN 19 '61</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1010

1010

(M)

8

8

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7028

07015

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE	
c. LENGTH OF STAY IN 1b 2 DAYS 8 HOURS		d. STREET ADDRESS SUB URBAN	

3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First LILLIAN Middle R. Last SHIPLEY </div>			4. DATE OF DEATH Month JUNE Day 22 Year 19 61		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/86		
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) MARION STATION, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
--	--	---	--	---	--	--	--

13. FATHER'S NAME GEORGE THOMAS MADDOX		14. MOTHER'S MAIDEN NAME EVELYN DORSEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET L. SHIPLEY		4858 Battery Lane Bethesda, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mos 15 yrs	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	

21. I certify that (I) (this hospital) attended the deceased from **Oct 21, 1959** to **June 22, 1961**, that (I) (we) last saw the deceased alive on **June 21, 1961**, and that death occurred at **8:01 A.M.** from the causes and on the date stated above.

22a. SIGNATURE W. S. Murphy		22b. DATE SIGNED 22 June 61	
22c. PHYSICIAN'S NAME (Type) W. S. Murphy		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 615 W. Montgomery, Rockville, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-61		23c. NAME OF CEMETERY OR CREMATORY Springfield		23d. LOCATION (City, town or county) (State) Sykesville, Carroll Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Haight	

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7013

7083



X

61

33

108

34124

5

12124

x

74

8/27/66

WHITE

WHITE

U.S.

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS



MASSACHUSETTS

MASSACHUSETTS

[Faint, illegible handwritten text at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7029

07016

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

19 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

e. STATE

Maryland

f. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

15

d. STREET ADDRESS

9810 Arborhill Drive

g. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Goldie

MMN

Slavin

4. DATE OF DEATH

Month

Day

Year

June 13 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☐

8. DATE OF BIRTH

September 10, 1885 75 yrs.

9. AGE (In years last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Minkin

14. MOTHER'S MAIDEN NAME

(Deceased) Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Address

Washington Sanitarium and Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a).

157X

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

Carcinoma of the pancreas

INTERVAL BETWEEN ONSET AND DEATH

2 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-26, 1961 to 6-13, 1961, that (I) (we) last saw the deceased alive on 6-12, 1961, and that death occurred at 11-PM, from the causes and on the date stated above.

22a. SIGNATURE

ABRAHAM W. DAVIS

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

6-13-61

22c. PHYSICIAN'S NAME (Type)

ABRAHAM W. DAVIS

22d. ADDRESS

927 Pershing Rd. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE OF BURIAL

6/14/61

23c. NAME OF CEMETERY OR CREMATORY

GEO. WASH. CEM.

23d. LOCATION (City, town or county)

Hyattsville Md

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Sheldene T. Walke

ADDRESS

4717-92nd St. NW

25a. REC'D BY REGISTRAR

DATE JUN 14 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

Washington

Takoma Park

Washington, D.C. 20010

Goldie

born 1910

Female white

Hausen

Russia

U.S.A.

Jacob Mink

(born 1910)

No

Washington, D.C. 20010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1
2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07017

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Albany Avenue Oakhaven Convalescent Home</u>		d. STREET ADDRESS <u>1707 Columbia Road N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Tallulah de Sales Smith</u>		4. DATE OF DEATH <u>June 30 1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Worker - Claim Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. Adm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dr. Zadoc Baker</u>		14. MOTHER'S MAIDEN NAME <u>Tallulah Abrams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs John Moulden</u>		Address <u>1107 Merwood Dr. Takoma Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>CARCINOMA OF THE CERVIX</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 1960</u> to <u>6-30 1961</u> , that (I) (we) last saw the deceased alive on <u>6-29 1961</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR. MD.</u>		22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/1/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St., N.W. Washington 9, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>JUL 3 '61</u>	

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47X-3

07013

CERTIFICATE OF DEATH

7030



DC

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate is retained by the hospital or attending physician and is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7031

07018

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 8317 41th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dennis Keith SMITHERS		4. DATE OF DEATH June 23 19 61	
5. SEX Male 6. COLOR OR RACE Cauc 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-82 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps 10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard S. SMITHERS		14. MOTHER'S MAIDEN NAME Helen MANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT (S) Robert Howard SMITHERS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (U) (this hospital) attended the deceased from 10 June 1961 to 23 June 1961 , that (U) (we) last saw the deceased alive on 23 June 1961 , and that death occurred 9:20PM from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-24-61 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W.P. BAKER LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City, town or county) (State) Church Road, N.W., Washington, DC	
24. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey		25a. REC'D BY REGISTRAR 4434 Georgia Ave. Silver Spring, Md. DATE JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Montgomery

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1-13-02

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U.S. Marine Corps

Virginia

US

Howard S. Williams

United States

Yes Unknown

(3) Robert's name Williams

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23 June 01

10 June 01

2:30 PM

23 June 01

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0-20-01

X

U.S. Naval Hospital, Bethesda, Maryland

P. H. BAKER JR MC USN

Serial

Rock Creek

2334 Georgia Ave.

U.S. Postmaster General Home Silver Spring, Md.

Church Road, H.W., Washington, DC

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07019

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Dist of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6201 12th St NW.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>R.</u> <u>SNAPP</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>7</u> <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>February 26 1875</u>			
9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JOHN SHIRLEY</u>				14. MOTHER'S MAIDEN NAME <u>REBECA NAGLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Lola V. Kelley (Niece)</u>			
17. INFORMANT Address <u>11011 Amherst Dr. Silver Spring Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1951</u> to <u>June 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/7, 1961</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John E. Everett</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>6/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>				22d. ADDRESS <u>9400 CONN. AVE KENSINGTON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. HERBON</u>			
23d. LOCATION (City, town or county) <u>WINCHESTER VA</u>		25a. REC'D BY REGISTRAR <u>JUN 12 '61</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAK FUNERAL HOME 4812 Oakley Woodlawn</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL
death. Page 4 m
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7033

07020

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural c. LENGTH OF STAY IN 1b 7 mos. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Waverley Sanitarium		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington 7 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 d. STREET ADDRESS 3252 O St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Norton Spencer		4. DATE OF DEATH Month Day Year June 20 19 61	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1882
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Buffalo, New York	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathaniel W. Norton		14. MOTHER'S MAIDEN NAME Mary C. Minor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs Henry Day, 3252 O St., N.W. Wash. 7 D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriolosclerosis Generalized DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 3 mont hs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Nephritis (Nephrosclerosis)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-17-60 to 6-20 , 19 61 that (I) (we) last saw the deceased alive on 6-20- 19 61 , and that death occurred at 2:30 p.m. from the causes and on the date stated above.		22a. SIGNATURE Frederic D. Chapman M.D.	
22b. PHYSICIAN'S NAME (Type) Frederic D. Chapman		22c. ADDRESS 1150 Conn Ave. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/23/61	
23c. NAME OF CEMETERY OR CREMATORY St. Michael's churchyard		23d. LOCATION (City, town or county) (State) Litchfield, Connecticut.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Borski		25a. REC'D BY REGISTRAR DATE JUN 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 3034 m Street, N.W.	

VR A15 (4)
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1913-1914

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07021

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Silver Spring</u> d. STREET ADDRESS <u>10,026 Lorain Avenue</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>13 years</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10,026 Lorain Avenue</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>August P. Spigone</u>				4. DATE OF DEATH Month Day Year <u>June 16, 19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 11, 1982</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Raleigh Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Rome Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Guy Spigone</u>				14. MOTHER'S MAIDEN NAME <u>Maria Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-14-3495</u>		17. INFORMANT <u>Miss Violet Spigone, 10,026 Lorain Ave., SS., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Occlusion</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus -----Years</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/16/61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 22 '61</u>			
<u>Raymond A. Ziska</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7035

Reg. Dist. No. 07022

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 Broadwood Dr</u>				d. STREET ADDRESS <u>1315 Broadwood Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Michael John Stahl</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-61</u>	
9. AGE (in years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family Service Montg Co - Rockville Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fishburn</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 7 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2251212 XV4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF CORONER [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]		CITY [Faint text]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT, CHAPTER 43, § 4-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT, CHAPTER 43, § 4-102.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
7037											
07024											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Sanitarium 10231 Carroll Place						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2013 Osborn Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Alverda Summers						4. DATE OF DEATH June 19, 1961					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1867		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Curtis						14. MOTHER'S MAIDEN NAME Hannah Montgomery					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Records at Sanitarium-10231 Carroll Pl. Kensington, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Illness 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 da 5 yrs											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1956 to June 19, 1961 , that (I) (we) last saw the deceased alive on June 18, 1961 , and that death occurred at 1035 A.M. from the causes and on the date stated above. 22a. SIGNATURE Arthur H. Lewis M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS M.D. 22d. ADDRESS 1714 R I Ave NW Wash DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/21/1961		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery				23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St. N.W. Washington 9, D.C.						25a. REC'D BY REGISTRAR JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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Nonconformity

Renovation

Local Council of the
County of the

Alverton

Female White

Household

Alverton, British

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Renovation

Local Council of the

Alverton

Female White

Household

Alverton, British

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death by a physician, hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7038

07025

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fazewell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 171 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Amonate	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS No street address			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Benny Last Sutherland				4. DATE OF DEATH Month June Day 4 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1944	
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min. 17		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Denny Sutherland, Jr.				14. MOTHER'S MAIDEN NAME Faye Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last, (b) Gram Negative Septicemia DUE TO (c) 1 week						INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) December 15, 60 June 4, 61				20g. (City or town) (County) (State) June 4, 61 4:00 PM			
21. I certify that (I) (this hospital) attended the deceased from June 4, 61 to June 4, 61 , that (I) (we) last saw the deceased alive on June 4, 61 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Rieselbach				22b. DATE 6-5-61			
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/6/61		23c. NAME OF CEMETERY OR CREMATORY Richlands, Va.		23d. LOCATION (City, town, or county) (State) Richlands, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 1400 Chapin St. N.W. Wash., D.C.		25a. REC'D BY REGISTRAR JUN 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline				25c. DATE JUN 7 '61			

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2302

CERTIFICATE OF DEATH

2302

(M)

Residence

Virginia

Age

Occupation

Married

171 days

Residence

No record address

The Clinical Center, Bethesda 1, Md.

June 1, 1961

Sutherland

Henry

James

171

March 2, 1961

White

Male

U.S.A.

Virginia

None

Student

Raye Harrison

Geny Sutherland, Jr.

The Medical Record

The Clinical Center, Bethesda 1, Maryland

None

No

Acute Myocardial Infarction

Death Negative Ecchymosis

2 mos.

1 week

December 12, 60 June 11

1961

61

June 11

1961

The Clinical Center, National Institutes of Health, Bethesda 1, Maryland

RICHARD E. KUBRICK, M.D.

1
 ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO HOSPITAL: Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 7039

07026

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>				d. STREET ADDRESS <u>10614 Edgewood Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10,614 Edgewood Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosalie</u> Middle <u>B</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>Aug</u> Day <u>30</u> Year <u>1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John S. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>M. Mary Nealon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Sister (Grace R. Noone)</u>				Address <u>4201</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO (b) <u>arteriosclerosis cordis-vase dila</u> DUE TO (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>60</u> to <u>June</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8 June</u> , 19 <u>61</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul T. Noone</u>				22b. DATE SIGNED <u>June 9, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Paul T. Noone</u>				22d. ADDRESS <u>6201 Randolph Rd. Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery, Montgomery, Md.</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Handwritten notes, possibly a list or ledger, with various entries and numbers. Includes phrases like "to the", "15th", "10th", "1st", "2nd", "3rd", "4th", "5th", "6th", "7th", "8th", "9th", "10th", "11th", "12th", "13th", "14th", "15th", "16th", "17th", "18th", "19th", "20th", "21st", "22nd", "23rd", "24th", "25th", "26th", "27th", "28th", "29th", "30th", "31st", "1st", "2nd", "3rd", "4th", "5th", "6th", "7th", "8th", "9th", "10th", "11th", "12th", "13th", "14th", "15th", "16th", "17th", "18th", "19th", "20th", "21st", "22nd", "23rd", "24th", "25th", "26th", "27th", "28th", "29th", "30th", "31st".

(I)

Handwritten notes at the bottom of the page, including a large signature or name "John P. Taylor" and other illegible text.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DRIVEWAY, 905 BONIFANT STREET					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 26 SILVER SPRING d. STREET ADDRESS 18301 - 16th STREET, APT. 303 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SONDRA			First Middle Last TRAGER		4. DATE OF DEATH JUNE 26		Month Day Year 19 61		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 25, 1936		9. AGE (In years last birthday) 24 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MARCUS COHEN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT POLICE RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X CEREBRAL HEMORRHAGE AND LACERATION DUE TO Conditions, if any, which gave rise to immediate cause (b) BULLET WOUND THROUGH SKULL (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): FOUND DEAD IN HER AUTO WITH SELF INFLICTED BULLET WOUND THROUGH SKULL								INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 2 p.m. JUNE 26 1961			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AUTO IN DRIVEWAY		20f. (City or town) SILVER SPRING, MONTGOMERY, MD. (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED JUNE 26, 1961		
EXAMINER'S NAME (Type) FRANK J. BROSCART					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/61		22c. NAME OF CEMETERY OR CREMATORY OHR KNEESETH ISRAEL CEM.		22d. LOCATION (City, town, or country) (State) Baltimore Md.			
23. FUNERAL DIRECTOR B. Danzansky & Sons				ADDRESS 3501 14th St., NW Wash. D.C.		24a. REC'D BY REGISTRAR JUN 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7042

07029

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Milo M Middle Van Noy Last 34				4. DATE OF DEATH Month June 15 Day 19 Year 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/93	
9. AGE (In years lost birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anderson L. Van Noy				14. MOTHER'S MAIDEN NAME Etura Dunson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 501-09-8972		17. INFORMANT Mary L. Nigh (daughter) Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO Sudden (c) Coronary Arteriosclerosis DUE TO hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. Status postoperative, Amputation Right Leg. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1 to 6-15 19 61 that (I) (we) last saw the deceased alive on 6-14 19 61 , and that death occurred at 7 AM, from the causes and on the date stated above.							
22a. SIGNATURE Jason Geiger		22b. DATE SIGNED 6-15-61		22c. PHYSICIAN'S NAME (Type) Jason Geiger		22d. ADDRESS Maryland 1112 Silver Spring Avenue, Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 6/16/61		23c. NAME OF CEMETERY OR CREMATORY Paint Township Cemetery		23d. LOCATION (City, town, or county) (State) London Madison County Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland				25a. REC'D BY REGISTRAR DATE JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

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CERTIFICATE OF DEATH

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1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1925*

5. Date of death: *Jan 20 1970*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *Dr. J. Smith*

9. Signature of registrar: *John Doe*

10. Date of registration: *Jan 25 1970*

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the law requires that the death certificate be executed within 72 hours after death. If the deceased was in a hospital or attending physician, the law requires that the death certificate be executed within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7043

07030

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 74 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Bluefield c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 d. STREET ADDRESS 226 Larch Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Charlotte Louise Vincent		4. DATE OF DEATH Month June Day 19 Year 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1915		9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk				10b. KIND OF BUSINESS OR INDUSTRY Commercial				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert H. Gilpin						14. MOTHER'S MAIDEN NAME Julia E. Hager													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure DUE TO 1939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glioblastoma Multiforme DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 mos. 4 mos.																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 6, 1961 to June 19, 1961 , that (I) (we) last saw the deceased alive on June 19, 1961 , and that death occurred at 9:04 p.m. from the causes and on the date stated above.																			
22a. SIGNATURE Philip J. Ferris, M.D.						22b. DATE SIGNED 6/20/61													
22c. PHYSICIAN'S NAME (Type) PHILIP J. FERRIS, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/22/61				23c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery				23d. LOCATION (City, town, or county) (State) Princeton, W. Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,						ADDRESS Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE JUN 22 '61				25b. REGISTRAR'S SIGNATURE Robert S. Travis			

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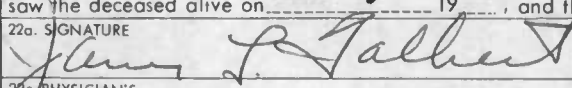

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VR A15 (4)
ISM 9/59

7044

07031

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodi		67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 56 Christopher Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary		Middle Ann		Last Voto	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 29, 1955	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Voto				14. MOTHER'S MAIDEN NAME Matilda Bauagnoli			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Following complete correction of tetralogy of Fallot DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 to June 8, 1961 , that (I) (we) last saw the deceased alive on June 8, 1961 , and that death occurred at 5:30AM , from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.				22b. DATE SIGNED 6/8/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23b. DATE THEREOF 6/8/1961		23c. NAME OF CEMETERY OR CREMATORY St. Nicholas Cem.		23d. LOCATION (City, town, or county) (State) Lodi New Jersey			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 9 '61	
				25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in a hospital or attending physician, the law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7045

07032

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 12 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 1127 Indiana Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Sherry Middle Anne Last Walden			4. DATE OF DEATH Month June Day 23 Year 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1954		9. AGE (In years lost birthday) yrs. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stanley Walden			14. MOTHER'S MAIDEN NAME Joan Watton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Tetralogy of Fallot DUE TO (c) Congenital					INTERVAL BETWEEN ONSET AND DEATH Res.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) June 11, 1961, to June 23, 1961	(County) June 23, 1961	(State) June 23, 1961
21. I certify that (I) (this hospital) attended the deceased from June 11, 1961 , to June 23, 1961 , that (I) (we) last saw the deceased alive on June 23, 1961 , and that death occurred at 10:00 PM from the causes and on the date stated above.					
22a. SIGNATURE O. W. Mc Bride		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-21-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) O.W. Mc Bride M.D.		22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-27-61	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) (State) Cape May Court House N.J.		
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale Md.		25a. REC'D BY REGISTRAR DATE JUN 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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57883

STATEMENT OF DEATH
OF
CLARENCE O. DEATH

Decedent's Name: CLARENCE O. DEATH
Date of Death: June 21, 1958
Place of Death: The Clinical Center, Bethesda, Md.
Age: 68
Sex: Male
Race: White
Marital Status: Married
Usual Residence: 1234 Main St., Washington, D.C.
Cause of Death: Myocardial Infarction
Immediate Cause: Coronary Atherosclerosis
Contributing Causes: Hypertension, Diabetes Mellitus
Occupation: Retired
Education: High School Graduate
Religion: Protestant
Signature of Physician: [Signature]
Signature of Medical Examiner: [Signature]
Signature of Coroner: [Signature]

Witnesses:
1. [Name], [Address], [City], [State], [Zip]
2. [Name], [Address], [City], [State], [Zip]
3. [Name], [Address], [City], [State], [Zip]
4. [Name], [Address], [City], [State], [Zip]
5. [Name], [Address], [City], [State], [Zip]
6. [Name], [Address], [City], [State], [Zip]
7. [Name], [Address], [City], [State], [Zip]
8. [Name], [Address], [City], [State], [Zip]
9. [Name], [Address], [City], [State], [Zip]
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82. [Name], [Address], [City], [State], [Zip]
83. [Name], [Address], [City], [State], [Zip]
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88. [Name], [Address], [City], [State], [Zip]
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91. [Name], [Address], [City], [State], [Zip]
92. [Name], [Address], [City], [State], [Zip]
93. [Name], [Address], [City], [State], [Zip]
94. [Name], [Address], [City], [State], [Zip]
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96. [Name], [Address], [City], [State], [Zip]
97. [Name], [Address], [City], [State], [Zip]
98. [Name], [Address], [City], [State], [Zip]
99. [Name], [Address], [City], [State], [Zip]
100. [Name], [Address], [City], [State], [Zip]

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7046 CERTIFICATE OF DEATH 07033											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> c. LENGTH OF STAY IN 1b <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3133 Conn. Ave. n.w.</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
3. NAME OF DECEASED (Type or print) <u>Elinor Gardiner Walker</u>		4. DATE OF DEATH <u>June 14 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1, 1881</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov't Employee</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		9c. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Davis</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Old Hospital Record</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Glomerular Nephritis</u> DUE TO (b) <u>Hypertension - Cardio-vascular and Chronic</u> DUE TO (c) <u>with Cardio neglect</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>no injury no accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u></u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				20g. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 24 1959</u> to <u>June 14 1961</u> , that (I) (we) last saw the deceased alive on <u>June 13 1961</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank L. Williamson</u> M.D.				22b. PHYSICIAN'S NAME (Type) <u>Frank L. Williamson</u>				22c. ADDRESS <u>2731 Conn Ave Washington</u>			
22d. DATE SIGNED <u></u>				22e. DATE SIGNED <u></u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>6/16/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Prince Georges County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co.</u>				24a. ADDRESS <u>2901 14 St NW</u>				24b. REC'D BY REGISTRAR <u>JUN 15 '61</u>			
24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				24d. REGISTRAR'S SIGNATURE <u></u>							

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(1)

James Co. 1901 14 21 1/2
Lore Lincoln Cemetery
Lore, Nebraska County, Neb.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7047

07034

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Summerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 224 North Summerset Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Bertie Middle Mae Last Ward		4. DATE OF DEATH		Month June Day 10 , Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1894		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Riggan				14. MOTHER'S MAIDEN NAME Louise Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myasthenia Gravis DUE TO (c) Arteriosclerotic Heart Disease							
INTERVAL BETWEEN ONSET AND DEATH 1 - 2 Hours 1 Year Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 3, 19 61 to June 10, 19 61 , that (I) (we) last saw the deceased alive on June 10, 19 61 , and that death occurred at 5:00AM from the causes and on the date stated above.							
22a. SIGNATURE Charles A. Payne, M.D.				22b. DATE SIGNED 6/10/61		22c. PHYSICIAN'S NAME (Type) Charles A. Payne M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-61		23c. NAME OF CEMETERY OR CREMATORY Crisfield Md.		23d. LOCATION (City, town, or county) (State) Crisfield Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee, J. H. Home				25a. REC'D BY REGISTRAR DATE JUN 13 '61		25b. REGISTRAR'S SIGNATURE Charles E. Home	

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CENTRAL HEALTH

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University of Maryland School of Medicine

Department of Pathology

The Clinical Center, Bethesda 1, Md.

Section of Hematology

Case No. 100-100000-100000

Received from the

Department of Pathology

The Clinical Center, Bethesda 1, Md.

1 - 2 pages

1 page

Unknown

June 10, 1961

June 10, 1961

The Clinical Center, Bethesda 1, Md.

of Hematology, Bethesda 1, Md.

100-100000-100000

100-100000-100000

Page 4
24 hours after death
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07036

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash San & Hospital		d. STREET ADDRESS 5801 Taylor Road	
3. NAME OF DECEASED (Type or print) First Edward Middle H. Last Watts		4. DATE OF DEATH Month June Day 2 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28th 1910
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Kentucky	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Watts		14. MOTHER'S MAIDEN NAME Martha Duval	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 10-10-10-2	
17. INFORMANT Blanche Watts 5801 Taylor Rd, Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 min 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-26-61 , 19 61 , to 6-2-61 , 19 61 , that I last saw the deceased alive on 5-31-61 , 19 61 , and that death occurred on 6-2-61 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		DATE SIGNED 6-2-61	
PHYSICIAN'S NAME (Type) John P. Clum		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6-1961	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Indel.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Costello		ADDRESS 1722 N. Capital	
24a. REC'D BY REGISTRAR JUN 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

PLACE OF DEATH A. HOME		MARRIAGE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MARRIAGE		DATE OF DEATH		TIME OF DEATH	
1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. PLACE OF DEATH	
9. DATE OF BIRTH		10. SEX		11. AGE		12. RACE		13. OCCUPATION		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. PLACE OF DEATH	
17. DATE OF BIRTH		18. SEX		19. AGE		20. RACE		21. OCCUPATION		22. CAUSE OF DEATH		23. MANNER OF DEATH		24. PLACE OF DEATH	
25. DATE OF BIRTH		26. SEX		27. AGE		28. RACE		29. OCCUPATION		30. CAUSE OF DEATH		31. MANNER OF DEATH		32. PLACE OF DEATH	
33. DATE OF BIRTH		34. SEX		35. AGE		36. RACE		37. OCCUPATION		38. CAUSE OF DEATH		39. MANNER OF DEATH		40. PLACE OF DEATH	
41. DATE OF BIRTH		42. SEX		43. AGE		44. RACE		45. OCCUPATION		46. CAUSE OF DEATH		47. MANNER OF DEATH		48. PLACE OF DEATH	
49. DATE OF BIRTH		50. SEX		51. AGE		52. RACE		53. OCCUPATION		54. CAUSE OF DEATH		55. MANNER OF DEATH		56. PLACE OF DEATH	
57. DATE OF BIRTH		58. SEX		59. AGE		60. RACE		61. OCCUPATION		62. CAUSE OF DEATH		63. MANNER OF DEATH		64. PLACE OF DEATH	
65. DATE OF BIRTH		66. SEX		67. AGE		68. RACE		69. OCCUPATION		70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF DEATH	
73. DATE OF BIRTH		74. SEX		75. AGE		76. RACE		77. OCCUPATION		78. CAUSE OF DEATH		79. MANNER OF DEATH		80. PLACE OF DEATH	
81. DATE OF BIRTH		82. SEX		83. AGE		84. RACE		85. OCCUPATION		86. CAUSE OF DEATH		87. MANNER OF DEATH		88. PLACE OF DEATH	
89. DATE OF BIRTH		90. SEX		91. AGE		92. RACE		93. OCCUPATION		94. CAUSE OF DEATH		95. MANNER OF DEATH		96. PLACE OF DEATH	
97. DATE OF BIRTH		98. SEX		99. AGE		100. RACE		101. OCCUPATION		102. CAUSE OF DEATH		103. MANNER OF DEATH		104. PLACE OF DEATH	
105. DATE OF BIRTH		106. SEX		107. AGE		108. RACE		109. OCCUPATION		110. CAUSE OF DEATH		111. MANNER OF DEATH		112. PLACE OF DEATH	
113. DATE OF BIRTH		114. SEX		115. AGE		116. RACE		117. OCCUPATION		118. CAUSE OF DEATH		119. MANNER OF DEATH		120. PLACE OF DEATH	
121. DATE OF BIRTH		122. SEX		123. AGE		124. RACE		125. OCCUPATION		126. CAUSE OF DEATH		127. MANNER OF DEATH		128. PLACE OF DEATH	
129. DATE OF BIRTH		130. SEX		131. AGE		132. RACE		133. OCCUPATION		134. CAUSE OF DEATH		135. MANNER OF DEATH		136. PLACE OF DEATH	
137. DATE OF BIRTH		138. SEX		139. AGE		140. RACE		141. OCCUPATION		142. CAUSE OF DEATH		143. MANNER OF DEATH		144. PLACE OF DEATH	
145. DATE OF BIRTH		146. SEX		147. AGE		148. RACE		149. OCCUPATION		150. CAUSE OF DEATH		151. MANNER OF DEATH		152. PLACE OF DEATH	
153. DATE OF BIRTH		154. SEX		155. AGE		156. RACE		157. OCCUPATION		158. CAUSE OF DEATH		159. MANNER OF DEATH		160. PLACE OF DEATH	
161. DATE OF BIRTH		162. SEX		163. AGE		164. RACE		165. OCCUPATION		166. CAUSE OF DEATH		167. MANNER OF DEATH		168. PLACE OF DEATH	
169. DATE OF BIRTH		170. SEX		171. AGE		172. RACE		173. OCCUPATION		174. CAUSE OF DEATH		175. MANNER OF DEATH		176. PLACE OF DEATH	
177. DATE OF BIRTH		178. SEX		179. AGE		180. RACE		181. OCCUPATION		182. CAUSE OF DEATH		183. MANNER OF DEATH		184. PLACE OF DEATH	
185. DATE OF BIRTH		186. SEX		187. AGE		188. RACE		189. OCCUPATION		190. CAUSE OF DEATH		191. MANNER OF DEATH		192. PLACE OF DEATH	
193. DATE OF BIRTH		194. SEX		195. AGE		196. RACE		197. OCCUPATION		198. CAUSE OF DEATH		199. MANNER OF DEATH		200. PLACE OF DEATH	
201. DATE OF BIRTH		202. SEX		203. AGE		204. RACE		205. OCCUPATION		206. CAUSE OF DEATH		207. MANNER OF DEATH		208. PLACE OF DEATH	
209. DATE OF BIRTH		210. SEX		211. AGE		212. RACE		213. OCCUPATION		214. CAUSE OF DEATH		215. MANNER OF DEATH		216. PLACE OF DEATH	
217. DATE OF BIRTH		218. SEX		219. AGE		220. RACE		221. OCCUPATION		222. CAUSE OF DEATH		223. MANNER OF DEATH		224. PLACE OF DEATH	
225. DATE OF BIRTH		226. SEX		227. AGE		228. RACE		229. OCCUPATION		230. CAUSE OF DEATH		231. MANNER OF DEATH		232. PLACE OF DEATH	
233. DATE OF BIRTH		234. SEX		235. AGE		236. RACE		237. OCCUPATION		238. CAUSE OF DEATH		239. MANNER OF DEATH		240. PLACE OF DEATH	
241. DATE OF BIRTH		242. SEX		243. AGE		244. RACE		245. OCCUPATION		246. CAUSE OF DEATH		247. MANNER OF DEATH		248. PLACE OF DEATH	
249. DATE OF BIRTH		250. SEX		251. AGE		252. RACE		253. OCCUPATION		254. CAUSE OF DEATH		255. MANNER OF DEATH		256. PLACE OF DEATH	
257. DATE OF BIRTH		258. SEX		259. AGE		260. RACE		261. OCCUPATION		262. CAUSE OF DEATH		263. MANNER OF DEATH		264. PLACE OF DEATH	
265. DATE OF BIRTH		266. SEX		267. AGE		268. RACE		269. OCCUPATION		270. CAUSE OF DEATH		271. MANNER OF DEATH		272. PLACE OF DEATH	
273. DATE OF BIRTH		274. SEX		275. AGE		276. RACE		277. OCCUPATION		278. CAUSE OF DEATH		279. MANNER OF DEATH		280. PLACE OF DEATH	
281. DATE OF BIRTH		282. SEX		283. AGE		284. RACE		285. OCCUPATION		286. CAUSE OF DEATH		287. MANNER OF DEATH		288. PLACE OF DEATH	
289. DATE OF BIRTH		290. SEX		291. AGE		292. RACE		293. OCCUPATION		294. CAUSE OF DEATH		295. MANNER OF DEATH		296. PLACE OF DEATH	
297. DATE OF BIRTH		298. SEX		299. AGE		300. RACE		301. OCCUPATION		302. CAUSE OF DEATH		303. MANNER OF DEATH		304. PLACE OF DEATH	
305. DATE OF BIRTH		306. SEX		307. AGE		308. RACE		309. OCCUPATION		310. CAUSE OF DEATH		311. MANNER OF DEATH		312. PLACE OF DEATH	
313. DATE OF BIRTH		314. SEX		315. AGE		316. RACE		317. OCCUPATION		318. CAUSE OF DEATH		319. MANNER OF DEATH		320. PLACE OF DEATH	
321. DATE OF BIRTH		322. SEX		323. AGE		324. RACE		325. OCCUPATION		326. CAUSE OF DEATH		327. MANNER OF DEATH		328. PLACE OF DEATH	
329. DATE OF BIRTH		330. SEX		331. AGE		332. RACE		333. OCCUPATION		334. CAUSE OF DEATH		335. MANNER OF DEATH		336. PLACE OF DEATH	
337. DATE OF BIRTH		338. SEX		339. AGE		340. RACE		341. OCCUPATION		342. CAUSE OF DEATH		343. MANNER OF DEATH		344. PLACE OF DEATH	
345. DATE OF BIRTH		346. SEX		347. AGE		348. RACE		349. OCCUPATION		350. CAUSE OF DEATH		351. MANNER OF DEATH		352. PLACE OF DEATH	
353. DATE OF BIRTH		354. SEX		355. AGE		356. RACE		357. OCCUPATION		358. CAUSE OF DEATH		359. MANNER OF DEATH		360. PLACE OF DEATH	
361. DATE OF BIRTH		362. SEX		363. AGE		364. RACE		365. OCCUPATION		366. CAUSE OF DEATH		367. MANNER OF DEATH		368. PLACE OF DEATH	
369. DATE OF BIRTH		370. SEX		371. AGE		372. RACE		373. OCCUPATION		374. CAUSE OF DEATH		375. MANNER OF DEATH		376. PLACE OF DEATH	
377. DATE OF BIRTH		378. SEX		379. AGE		380. RACE		381. OCCUPATION		382. CAUSE OF DEATH		383. MANNER OF DEATH		384. PLACE OF DEATH	
385. DATE OF BIRTH		386. SEX		387. AGE		388. RACE		389. OCCUPATION		390. CAUSE OF DEATH		391. MANNER OF DEATH		392. PLACE OF DEATH	
393. DATE OF BIRTH		394. SEX		395. AGE		396. RACE		397. OCCUPATION		398. CAUSE OF DEATH		399. MANNER OF DEATH		400. PLACE OF DEATH	
401. DATE OF BIRTH		402. SEX		403. AGE		404. RACE		405. OCCUPATION		406. CAUSE OF DEATH		407. MANNER OF DEATH		408. PLACE OF DEATH	
409. DATE OF BIRTH		410. SEX		411. AGE		412. RACE		413. OCCUPATION		414. CAUSE OF DEATH		415. MANNER OF DEATH		416. PLACE OF DEATH	
417. DATE OF BIRTH		418. SEX		419. AGE		420. RACE		421. OCCUPATION		422. CAUSE OF DEATH		423. MANNER OF DEATH		424. PLACE OF DEATH	
425. DATE OF BIRTH		426. SEX		427. AGE		428. RACE		429. OCCUPATION		430. CAUSE OF DEATH		431. MANNER OF DEATH		432. PLACE OF DEATH	
433. DATE OF BIRTH		434. SEX		435. AGE		436. RACE		437. OCCUPATION		438. CAUSE OF DEATH		439. MANNER OF DEATH		440. PLACE OF DEATH	
441. DATE OF BIRTH		442. SEX		443. AGE		444. RACE		445. OCCUPATION		446. CAUSE OF DEATH		447. MANNER OF DEATH		448. PLACE OF DEATH	
449. DATE OF BIRTH		450. SEX		451. AGE		452. RACE		453. OCCUPATION		454. CAUSE OF DEATH		455. MANNER OF DEATH		456. PLACE OF DEATH	
457. DATE OF BIRTH		458. SEX		459. AGE		460. RACE		461. OCCUPATION		462. CAUSE OF DEATH		463. MANNER OF DEATH		464. PLACE OF DEATH	
465. DATE OF BIRTH		466. SEX		467. AGE		468. RACE		469. OCCUPATION		470. CAUSE OF DEATH		471. MANNER OF DEATH		472. PLACE OF DEATH	
473. DATE OF BIRTH		474. SEX		475. AGE		476. RACE		477. OCCUPATION		478. CAUSE OF DEATH		479. MANNER OF DEATH		480. PLACE OF DEATH	
481. DATE OF BIRTH		482. SEX		483. AGE		484. RACE		485. OCCUPATION		486. CAUSE OF DEATH		487. MANNER OF DEATH		488. PLACE OF DEATH	
489. DATE OF BIRTH		490. SEX		491. AGE		492. RACE		493. OCCUPATION		494. CAUSE OF DEATH		495. MANNER OF DEATH		496. PLACE OF DEATH	
497. DATE OF BIRTH		498. SEX		499. AGE		500. RACE		501. OCCUPATION		502. CAUSE OF DEATH		503. MANNER OF DEATH		504. PLACE OF DEATH	
505. DATE OF BIRTH		506. SEX		507. AGE		508. RACE		509. OCCUPATION		510. CAUSE OF DEATH		511. MANNER OF DEATH		512. PLACE OF DEATH	
513. DATE OF BIRTH		514. SEX		515. AGE		516. RACE		517. OCCUPATION		518. CAUSE OF DEATH		519. MANNER OF DEATH		520. PLACE OF DEATH	
521. DATE OF BIRTH		522. SEX		523. AGE		524. RACE		525. OCCUPATION		526. CAUSE OF DEATH		527. MANNER OF DEATH		528. PLACE OF DEATH	
529. DATE OF BIRTH		530. SEX		531. AGE		532. RACE		533. OCCUPATION		534. CAUSE OF DEATH		535. MANNER OF DEATH		536. PLACE OF DEATH	
537. DATE OF BIRTH		538. SEX		539. AGE		540. RACE		541. OCCUPATION		542. CAUSE OF DEATH		543. MANNER OF DEATH		544. PLACE OF DEATH	
545. DATE OF BIRTH		546. SEX		547. AGE		548. RACE		549. OCCUPATION		550. CAUSE OF DEATH		551. MANNER OF DEATH		552. PLACE OF DEATH	
553. DATE OF BIRTH		554. SEX		555. AGE		556. RACE		557. OCCUPATION		558. CAUSE OF DEATH		559. MANNER OF DEATH		560. PLACE OF DEATH	
561. DATE OF BIRTH		562. SEX		563. AGE		564. RACE		565. OCCUPATION		566. CAUSE OF DEATH		567. MANNER OF DEATH		568. PLACE OF DEATH	
569. DATE OF BIRTH		570. SEX		571. AGE		572. RACE		573. OCCUPATION		574. CAUSE OF DEATH		575. MANNER OF DEATH		576. PLACE OF DEATH	
577. DATE OF BIRTH		578. SEX		579. AGE		580. RACE		581. OCCUPATION		582. CAUSE OF DEATH		583. MANNER OF DEATH		584. PLACE OF DEATH	
585. DATE OF BIRTH		586. SEX		587. AGE		588. RACE		589. OCCUPATION		590. CAUSE OF DEATH		591. MANNER OF DEATH		592. PLACE OF DEATH	
593. DATE OF BIRTH		594. SEX		595. AGE		596. RACE		597. OCCUPATION		598. CAUSE OF DEATH		599. MANNER OF DEATH		600. PLACE OF DEATH	
601. DATE OF BIRTH		602. SEX		603. AGE		604. RACE		605. OCCUPATION		606. CAUSE OF DEATH		607. MANNER OF DEATH		608. PLACE OF DEATH	
609. DATE OF BIRTH		610. SEX		611. AGE		612. RACE		613. OCCUPATION		614. CAUSE OF DEATH		615. MANNER OF DEATH		616. PLACE OF DEATH	
617. DATE OF BIRTH		618. SEX		619. AGE		620. RACE		621. OCCUPATION		622. CAUSE OF DEATH		623. MANNER OF DEATH		624. PLACE OF DEATH	
625. DATE OF BIRTH		626. SEX		627. AGE		628. RACE		629. OCCUPATION		630. CAUSE OF DEATH		631. MANNER OF DEATH		632. PLACE OF DEATH	
633. DATE OF BIRTH		634. SEX		635. AGE		636. RACE		637. OCCUPATION		638. CAUSE OF DEATH		639. MANNER OF DEATH		640. PLACE OF DEATH	
641. DATE OF BIRTH		642. SEX		643. AGE		644. RACE		645. OCCUPATION		646. CAUSE OF DEATH		647. MANNER OF DEATH		648. PLACE OF DEATH	
649. DATE OF BIRTH		650. SEX		651. AGE		652. RACE		653. OCCUPATION		654. CAUSE OF DEATH		655. MANNER OF DEATH		656. PLACE OF DEATH	
657. DATE OF BIRTH		658. SEX		659. AGE		660. RACE		661. OCCUPATION		662. CAUSE OF DEATH		663. MANNER OF DEATH		664. PLACE OF DEATH	
665. DATE OF BIRTH		666. SEX		667. AGE		668. RACE		669. OCCUPATION		670. CAUSE OF DEATH		671. MANNER OF DEATH		672. PLACE OF DEATH	
673. DATE OF BIRTH		674. SEX		675. AGE		676. RACE		677. OCCUPATION		678. CAUSE OF DEATH		679. MANNER OF DEATH		680. PLACE OF DEATH	
681. DATE OF BIRTH		682. SEX		683. AGE		684. RACE		685. OCCUPATION		686. CAUSE OF DEATH		687. MANNER OF DEATH		688. PLACE OF DEATH	
689. DATE OF BIRTH		690. SEX		691. AGE		692. RACE		693. OCCUPATION		694. CAUSE OF DEATH		695. MANNER OF DEATH		696. PLACE OF DEATH	
697. DATE OF BIRTH		698. SEX		699. AGE		700. RACE		701. OCCUPATION		702. CAUSE OF DEATH		703. MANNER OF DEATH		704. PLACE OF DEATH	
705. DATE OF BIRTH		706. SEX		707. AGE		708. RACE		709. OCCUPATION		710. CAUSE OF DEATH		711. MANNER OF DEATH		712. PLACE OF DEATH	
713. DATE OF BIRTH		714. SEX		715. AGE		716. RACE		717. OCCUPATION		718. CAUSE OF DEATH		719. MANNER OF DEATH		720. PLACE OF DEATH	
721. DATE OF BIRTH		722. SEX		723. AGE		724. RACE		725. OCCUPATION		726. CAUSE OF DEATH		727. MANNER OF DEATH		728. PLACE OF DEATH	
729. DATE OF BIRTH		730. SEX		731. AGE		732. RACE		733. OCCUPATION		734. CAUSE OF DEATH		735. MANNER OF DEATH		736. PLACE OF DEATH	
737. DATE OF BIRTH		738. SEX		739. AGE		740. RACE		741. OCCUPATION		742. CAUSE OF DEATH		743. MANNER OF DEATH		744. PLACE OF DEATH	
745. DATE OF BIRTH		746. SEX		747. AGE		748. RACE		749. OCCUPATION		750. CAUSE OF DEATH		751. MANNER OF DEATH		752. PLACE OF DEATH	
753. DATE OF BIRTH		754. SEX		755. AGE		756. RACE		757. OCCUPATION		758. CAUSE OF DEATH		759. MANNER OF DEATH		760. PLACE OF DEATH	
761. DATE OF BIRTH		762. SEX		763. AGE		764. RACE		765. OCCUPATION		766. CAUSE OF DEATH		767. MANNER OF DEATH		768. PLACE OF DEATH	
769. DATE OF BIRTH		770. SEX		771. AGE		772. RACE		773. OCCUPATION		774. CAUSE OF DEATH		775. MANNER OF DEATH		776. PLACE OF DEATH	
777. DATE OF BIRTH		778. SEX		779. AGE		780. RACE		781. OCCUPATION		782. CAUSE OF DEATH		783. MANNER OF DEATH		784. PLACE OF DEATH	
785. DATE OF BIRTH															

VS. A15ME
5M 7/59

07037

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE		b. COUNTY	
MONTGOMERY, Montgomery		Maryland		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring		10 yrs.		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1523 Grace Church Road		June 7, 1961			
3. NAME OF DECEASED (Type or print)		First		Middle	
Phyllis H.		Werder			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home RENTED		Green Bay, Wisconsin	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas F. Hawley		Alvina S. Libert		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		Will		Dr. Richard H. Werder, 1523 Grace Church Road, Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Strangulation by Hanging		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
974X		DUE TO			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)			
		DUE TO			
		(c)		4 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		Mental Depression			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
		Hung self with clothes line in basement			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:00 6/7/61 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
John G. Ball		M.D.		6/7/61	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
John G. Ball					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Removal		June 10, 1961		Green Bay Wisconsin	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey Inc.		8434 Georgia Ave.		DATE JUN 13 '61	
Raymond A. Ziska		Silver Spring, Md		Curtis L. Hume	

(M)

(I)

Standardized by Handley

Mental Depression

Mental Depression

Hand self and others in account

2-4/71

Home -

X

X

John A. Ball

Grand Jury

June 10, 1971

James E. Cox, Inc. 1124 Central Ave. Dayton, Ohio 45402

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7051

CERTIFICATE OF DEATH

07038

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 37 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent River d. STREET ADDRESS 773B MEMO Naval Air Station e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen Louise WHITE		4. DATE OF DEATH Month Day Year June 7 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (County & State, or foreign country) Maine
13. FATHER'S NAME Vernon L. FLEMMINGS		14. MOTHER'S MAIDEN NAME Marietta M. BENNETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. (H) John W. White, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic insufficiency DUE TO (b) Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 years	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 May 1 11:05 PM 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Bath Maine	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 1 11:05 PM 1961 to June 7 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 7 1961 , and that death occurred at 11:05 PM , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Bruce Harold Rice M.D.		22b. DATE SIGNED 6-8-61	
22c. PHYSICIAN'S NAME (Type) Bruce Harold RICE, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 6-9-61		23b. DATE THEREOF 6-9-61	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town or county) (State) Bath Maine	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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7052
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>25 Holt Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Lee</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-07</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>J. Henry Chavey</u>			
14. MOTHER'S MAIDEN NAME <u>Cordie Crawford</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Patient's Chart</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> DUE TO (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>Chronic Glomerulo - Nephritis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>3 months</u> <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>June 30 1961</u> , that (I) (we) last saw the deceased alive on <u>June 30 1961</u> , and that death occurred at <u>6:15 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>				22b. DATE SIGNED <u>6/30/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>				22d. ADDRESS <u>7600 Carroll Ave. T.P. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 4, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Rogersville TENN.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Hare</u> ADDRESS <u>254 Carroll St NW. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 3 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Calvin E. Hare</u>							

22072

CHRYSLER

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Robert J. ...
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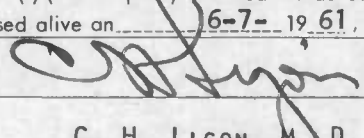
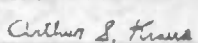
7054

MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07041

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				d. STREET ADDRESS 263 E EAST MONTGOMERY AVENUE			
3. NAME OF DECEASED (Type or print) First PATRICIA Middle ELAINE Last WILLOUGHBY				4. DATE OF DEATH Month JUNE Day 7 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 29, 1961	
9. AGE (In years lost birthday) 9 DAYS		IF UNDER 1 YEAR Months 9 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY INFANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILBERT HAR OLD WILLOUGHBY				14. MOTHER'S MAIDEN NAME ZELMA SHACKELFURD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHO-PNEUMONIA 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY (3-7y) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days 9 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from 5-29-61 to 6-7- 1961 , that (I) (we) last saw the deceased alive on 6-7- 1961 , and that death occurred at 6:23 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/8/61	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/61		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.				25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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HONTS HENRY

5 DAYS

5 C. MILES

505 E - 101 HONTS HENRY

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505 E - 101 HONTS HENRY

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DEATH

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7055 CERTIFICATE OF DEATH 07042									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Colorado b. COUNTY Trinidad c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1614 Buena Vista d. STREET ADDRESS 44X-3				
3. NAME OF DECEASED (Type or print) Robert Elmore WILSON		First Middle Last		4. DATE OF DEATH June 11 1961		Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-14-09		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME John Carl WILSON				14. MOTHER'S MAIDEN NAME Martha L. ELMORE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1928 to 1958 224-52-4475		17. INFORMANT (W) Mrs. Martha J. Wilson, 3222 1st Place, Arlington, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, liver, with metastasis 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 9 1961 to June 11 1961		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 9 8:50AM to June 11 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 11 1961 , and that death occurred at 8:50AM , from the causes and on the date stated above.									
22a. SIGNATURE <i>J. E. Stitcher</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-12-61			
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thayer</i> Arlington Funeral Home, 3901 N. Fairfax Dr.				ADDRESS Arlington, Va.		25a. REC'D BY REGISTRAR JUN 15 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thayer</i>	

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AL-8-1-1

Colonel

Richards (husb)

33 days

Richards

U. S. Naval Hospital

John Boone Wilson

Roberts

Blanco

Wilson

June

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Anderson

2-14-60

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U. S. Navy

Illinois

USA

John Carl Wilson

Martha A. Wilson

Washington, D.C.

1958 to 1959 204-22-1115 () Mrs. Martha A. Wilson, 221 1st Place,

Washington, D.C., with mother

(T)

x

May 9 8:30A

June 11

x

6-22-61

U. S. Attorney, 10, 10, 10

U. S. Naval Hospital, Bethesda, Md.

0-10-61

Washington Post and Times Herald

Washington

Washington General Hospital, 2001 E. Fairview Dr.

201 1st St

Washington, D.C.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07043

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 610 Hillman Drive			
3. NAME OF DECEASED (Type or print) First Marty Middle Ann Last Windle				4. DATE OF DEATH Month June Day 5 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 24, 1956	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 5 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Norman E. Windle				14. MOTHER'S MAIDEN NAME June Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Wilm's Tumor DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week 10 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 11 19 61 to June 5 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 5 19 61 , and that death occurred at 9:40 p.m. M, from the causes and on the date stated above.							
22a. SIGNATURE Jerome B. Block				22b. DATE 6/6/61			
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		6-9-61		Lebanon Church Cn.		Lebanon Church, Va	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md		25a. REC'D BY REGISTRAR JUN 8 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

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7028

CERTIFICATE OF DEATH

1902

11

Age

Virginia

Residence

Married

25 days

Witnesses

The Clinical Center, Bethesda, Md., 610 Michigan Drive

Early

Ann

Martha

June

21

Female

White

January 25, 1902

Child

Home

Virginia

1902

James E. Smith

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

Cardinal's office

Interstate 401

1000

June 2

July 11

June 2

June 2

James E. Smith, M.D.

The Clinical Center, Bethesda, Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
7057						07044					
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 SILVER SPRING d. STREET ADDRESS 11709 Galt Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Thomas W. Woltz						4. DATE OF DEATH Month June Day 20 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/73		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Charles E. Waltz						14. MOTHER'S MAIDEN NAME Mammie Landown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578-07-7755		17. INFORMANT Grace DeGroat Address 15 Erickson, Cabin John, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure & Emphysema 610x DUE TO (b) Prostatitis & Kidney Involvement Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) Fr. of Rt. Hip										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 to June 20, 1961 ; that (I) (we) last saw the deceased alive on 6/20/61 19 61 , and that death occurred at 5:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature] M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) [Signature]						22d. ADDRESS 8106 Maple Ridge Rd., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City, town or county) Southland Ind. (State)				
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 11812 9th Ave. Wash. DC						25. REC'D BY REGISTRAR [Signature] DATE JUN 23 '61			25b. REGISTRAR'S SIGNATURE [Signature]		

(M)

(I)

Bedford
Canton

17 days

1100 Main Avenue

1 00 Jan

Male x Male

Car. enter Private Virginia U.S.

Charles E. Watta

Married January

These tickets 15 London, Cabin John, Va.

CERTIFICATE OF DEATH

Reg. Dist. No.

07045

7058

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,	
c. LENGTH OF STAY IN lb 8 months		d. STREET ADDRESS 8712 Colesville Road, Apt. # 408	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bartlings Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mrs. Ella A. Wood Middle Last 		4. DATE OF DEATH Month June Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/73
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker -- Retired		10b. KIND OF BUSINESS OR INDUSTRY Boston Massachusetts	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. George Averill Mass.		14. MOTHER'S MAIDEN NAME Mrs. Georgianna Kendall Vermont	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Grant A. Wood		Address 8712 Colesville Road, Apt. 408 Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 1957, to June 12 , 1961, that I last saw the deceased alive on June 11 , 1961, and that death occurred at 7:20 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Seruech T. Kimble		ADDRESS (Street, city or town, state) 927 P. Washington Drive, Silver Spring, Maryland	
PHYSICIAN'S NAME (Type) Seruech T. Kimble		DATE SIGNED 6-12-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/14/61	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

M

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07046

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District Of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 18 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1721 Kilbourne Place, N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harlan Middle (None) Last Wood				4. DATE OF DEATH Month June Day 12, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1896		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Wood				14. MOTHER'S MAIDEN NAME Caroline Cannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT The Medical Records address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162-1) Bronchogenic Carcinoma, disseminated DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic Insufficiency, myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH 5 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 25, 19 61 to June 12, 19 61 , that (I) (we) last saw the deceased alive on June 12, 19 61 , and that death occurred at 5:39 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Michael W. Brandriss				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-12-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Michael W. Brandriss M.D.				22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. - Arlington, Virginia		23d. LOCATION (City, lawn, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. 2901 14th St., N.W.				25a. REC'D BY REGISTRAR JUN 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07046

CERTIFICATE OF DEATH

1955

M

State of Colorado

Montezuma

Washington

18 days

Barabara

The Clinical Center, Barabara J. W.

1721 Washington, Barabara J. W.

(none)

Wood

Marion

TX

White

Male

April 1, 1955

25

Law

Attorney

John G. Wood

Corvallis, Oregon

The National Bureau

Unsubstantiated The Clinical Center, Barabara J. W.

SW 1

Jan

Barabara J. W.

The Clinical Center, Barabara J. W.

May 25, 1955

June 15, 1955

1-1-1

The Clinical Center, Barabara J. W.

Barabara J. W.

The Clinical Center, Barabara J. W.

The Clinical Center, Barabara J. W.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7061
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07043

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 10503 Drumm Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Month June Day 23 Year 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-61
9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		12. KIND OF BUSINESS OR INDUSTRY -	
13. FATHER'S NAME Herman ZIFFER		14. MOTHER'S MAIDEN NAME Kathleen Mary MORRISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Herman Ziffer, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity with immaturity (Birth wgt. 1# 15 oz) DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) 776 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 21 to June 23 , 1961, that (X) (we) last saw the deceased alive on June 23 , 1961, and that death occurred at 9A M, from the causes and on the date stated above.			
22a. SIGNATURE Robert V Rack		22b. DATE SIGNED 6-23-61	
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 26 Jun 61	
23c. NAME OF CEMETERY OR CREMATORY J. Wm. Lees Sons Co.		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home, Fairfax, Va.		25a. REC'D BY REGISTRAR JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE JUN 27 '61	

17048

1001

(M)

Montgomery

Malaysia

Montgomery

Montgomery

2 days

Barbados (Jamaica)

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U. S. Naval Hospital

June 23 01

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Body Girl

6-21-61

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Korea

USA

Malaysia

British Army Hospital

British Army

(7) British Army, near 1000

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No

Examination with instrument (shown with 1000)

June 23 01

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June 21

June 23 01

6-23-61

Robert V. Ruck, Lt. Col., USA, U. S. Naval Hospital, Bethesda, Md.

Washington, D. C.

U. S. Naval Hospital, Bethesda, Md.

30 Jan 61

U. S. Naval Hospital, Bethesda, Md.